The discharge of long-stay psychiatric patients into the community : a study of the patients, the staff and the public.

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THE DISCHARGE OF LONG-STAY PSYCHIATRIC PATIENTS INTO THE COMMUNITY:

A STUDY OF THE PATIENTS, THE STAFF AND THE PUBLIC

BY

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ABSTRACT

Title of the study:

THE DISCHARGE OF LONG-STAY PSYCHIATRIC PATIENTS INTO THE COMMUNITY: A STUDY OF THE PATIENTS, THE STAFF AND THE PUBLIC.

Aim of the study:

To describe the transition of psychiatric patients moving from institutional care to community care, comparing results before and six months after discharge.

Objectives of the study:

1. To identify changes in patients' attitudes, mental state and social behaviour after living six and twelve months in the community compared with baseline.
2. To identify staff attitudes, needs and roles towards working outside mental hospitals.
3. To describe public concepts of mental illness living next to mental health facilities in Tottenham, North London.
4. To identify changes of neighbours' attitudes towards psychiatric patients who moved to live in their neighbourhood in Tottenham, North London.

Introduction:

1. Theoretical background: the study supports labelling theory since the literature review shows that the social characteristics of the psychiatric patients determine the type of the social reactions, independent of the psychiatric condition of the patient.

2. Importance of the study: the results of the study will provide information about the factors that might influence success or failure in the psychiatric patients' resettlement in the community.

3. Reviewing the literature which relates to this study: hospital closure, community services, assessment of patients' mental state and rehabilitation; staff attitudes and their preparation for work outside psychiatric hospitals; and also include studies of public attitudes and education about mental illness.

Methodology:

1. Structured interviews for twenty psychiatric patients, before their discharge from hospital, at six months and one year follow-up.
2. Tape recorded interviews with eighteen staff members when they began their work and six months later.
3. Repertory Grid Technique with eighteen local residents. The Repertory Grid Technique allows a quantitative estimate of attitudes change.
4. Semi-structured interviews with sixty-eight local residents and sixty control group

before patients' discharge and six months later.

Results and Discussion:

The overall results showed deterioration in patients' mental state. However, their hygiene, attitude toward community living, and social network showed positive changes.

Staff members showed confusion regarding their roles and expressed the need for theoretical as well as practical preparation before working outside the hospital.

Local residents' attitudes showed little changes. Demographic variables exerted no effect on their attitudes. Although local residents strongly object to hospital closure, they welcome opening mental health facilities in their area as they felt that they might need to use them. They labelled the mentally ill as strange, with poor communication, and potentially hostile toward children and public. Local residents expressed the desire to learn about mental illness. The study highlighted the need for staff and public education about mental illness. Finally, patients' rehabilitation is crucial for their reintegration in the community.

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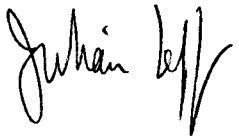
Declaration

Miss Reda collected the data in all four studies included in this thesis with the following exceptions: The one year follow-up data for the patients at the Grange were collected by a member of The Team for Assessment of Psychiatric Services (TAPS) and included in the thesis for comparison with the six month follow-up data collected by Miss Reda.

The inter-rater reliability of the questionnaire used in the study of public attitudes was established in collaboration with two assistant psychologists and a sociologist, who were members of TAPS.

All data analyses were conducted by Miss Reda with the exception of the data from the Repertory Grid study. These were analysed by Dr. Patrick Slater using a unique computer programme. The interpretation of this analysis was undertaken by Miss Reda.



Professor Julian Leff

CONTEXT OF THE RESEARCH PROJECT

British government policy for mental health is to move the focus of care from hospital towards community for the majority of psychiatric patients (Audit Commission, 1986; Department of Health, 1989). In 1983, the North East Thames Regional Health Authority (NETRHA) took the decision to close Friern and Claybury hospitals by March, 1993 in response to feasibility studies set up to examine four closure criteria: 1. the extent of local provision in the catchment areas; 2. condition of the buildings; 3. staff/patient ratios and 4. costs, site value and specialisation offered. In 1985 NETRHA decided to set up a research group, the Team for Assessment of Psychiatric Services (TAPS). The objectives of the team are to study the effect on patients of transition from hospital-based to community-based services. The main questions that TAPS addresses are: how is the move from the hospital to the community being managed, has the move proved better for long-term patients, how does the expense of community care compare with that of the hospitals, how does transfer from hospital affect elderly and demented patients, what are the effects of moving acute services into local districts? These findings will have important implications for the future development of mental health policy in Britain and other countries pursuing similar policies

The catchment areas of Friern and Claybury hospitals cover Camden, Islington, West Haringey, East Haringey, Enfield/Edmonton, Waltham Forest, West Essex and Redbridge. Camden and Haringey were the first to open mental health facilities in the community. NETRHA laid down a few guidelines but left it to the District Health Authorities (DHAs) to develop their own plans. These guidelines were: 1. patients should be moved with their friends, 2. new facilities should be as close as possible to the patients' original place of residence; 3. facilities for elderly patients should be homely and house a maximum of 24 residents. Each district, in collaboration with local authority and voluntary groups, was encouraged to develop its own philosophy and design its own residential accommodation. In fact the nine DHAs have provided very similar facilities for long-stay patients, including adult fostering, private lodgings, and staffed group homes. Most of the latter provide residential facilities for four or five former psychiatric patients, and have staff on the premises during the day, and sometimes at night as well.
The Grange was the first community mental health facility to open in the Tottenham area as part of the closure programme, and came into operation in 1987. It is unique because it provides a combination of a rehabilitation and re-location project, and is run and managed by Haringey Social Services and financed by the Local Health Authority. The purposes of the Grange according to the social services operational policy are:

1. To provide rehabilitation for life outside the hospital;
2. To initiate and develop activities according to patients' needs;
3. To attain and maintain each client's maximum potential for independent living, by:

a. assessing levels of current ability.

b. designing a programme of care with clear objectives to be achieved within a given period.

c. assessing patients' progress continuously.

d. finding permanent accommodation according to patients' needs.

e. providing continuous support following patients' discharge from the Grange.

4. The day centre will teach the patients skills of independent living. This will be achieved through developing training programmes about daily living (detailed description of the project on page 179).

This research project encompasses studies of patients moved to the Grange, the staff employed by Haringey Social Services Department to work with those patients, as well as the local residents living in the neighbourhood of the Grange.

The Theoretical Basis of The Design of The Study.

Even though the policy of psychiatric hospital closure is being widely implemented, few attempts have been made to measure the effect of this policy on the people who are most affected: the patients, staff members and local residents. Therefore it was decided to include all three groups as subjects in this series of studies.

Because so little research has been done in this area, it is necessary to develop new research methods and designs, and to pilot them. This research set out to test new methods across a wide range of subjects, including, patients, members of the public and staff members. In view of the pilot nature of this research, it was not expected to yield definitive results, however, the testing of instruments and strategies was intended to provide a sound basis for future research in this area.

The design of this study rests on the assumption that the first six months after opening the Grange are important for the patients and the staff because most problems are likely to arise during this period. It also made it possible to study the process of selecting the patients for a project and the staff approach to coping with this process.

The design is based on the hypothesis that patients' readjustment in the community will depend on their preparation before discharge, and on staff and public attitudes towards community care. Similarly, staff roles in the community will depend on their attitudes and their preparation for work outside psychiatric hospitals. Furthermore, public attitudes toward former psychiatric patients are crucial for patients' adjustment in the community, and will depend on former psychiatric patients' preparation to live in the community, as well as staff roles in the community. This analysis of the design of the study explains how the four parts of the study complement each other.

The study is viewed as a natural experiment, where no changes in the circumstances will be made by the researcher, because of limited control over the services provided by the Grange; however, in the public study it was possible to set up a control group.

This research project is intended to introduce new research methods into the study of community care. The principle aim is to investigate the possibility of assessing public attitudes toward community care on a large scale. A new semi-structured interview questionnaire will be piloted. Similarly, the feasibility will be examined of using the Repertory Grid Technique as a measure of quantitative change in attitudes over time in a public survey. A further aim is to pilot a new questionnaire to study staff roles during the transitional period of mental health care. This area has not been investigated before, so that, the results will help in planning similar studies in the future. Regarding the patients' study, this research will employ a set of questionnaires intended for former psychiatric patients who have moved into the community after a long period of care in a psychiatric hospital.

Rationale for the research measurements:

1. Semi-structured interview to assess public attitudes: This study centres on the notion that recognition of the mentally ill is related to the extent to which the behaviour of the mentally ill person deviates from normality. It has been suggested that community resistance stems from the identification of the deviant behaviour of formerly institutionalised patients. Such identification derives from several myths and fears. Therefore the questionnaire aims at recording the local residents' perceptions of mentally ill people, along with other groups who may show socially deviant behaviour described by the public in a pilot study. The questionnaire is designed to elicit the public's perceptions in their own words without any suggestions from the interviewer. The questionnaire will also identify the public's stated needs for preparation. It is also intended to define the specific group to be targeted for an education programme. After six months the same questionnaire will be repeated with the same subjects to investigate whether or not coming into contact with former psychiatric patients would affect the way they perceived them. The questionnaire will record any contacts or incidents that occurred between the subjects under study and former patients in their neighbourhood.

2. Repertory Grid Technique: The rationale behind the use of the Repertory Grid Technique with the local residents in this study is to complement the semi-structured questionnaire. It is a contrasting method because it is highly structured although the constructs are derived from a preliminary open ended enquiry.

This questionnaire has the advantage of collecting data on opinions and attitudes without the subject being aware of any socially desirable responses. It generates a large mass of data on a small sample of subjects. Therefore it would be unrepresentative to use it on its

own. However, in conjunction with a large-scale survey questionnaire, it can provide valuable confirmation of the less intensive method of eliciting opinions and attitudes.

3. In the patients' study the design used aimed at discovering whether or not changes in patients can be detected over a six month period using an extensive batch of questionnaires. Since there is no control group, one cannot be sure that these changes are due to moving to a new facility or to the time course of their illness. One could argue that the move to a new facility is more likely to have a detectable effect on patients' behaviour than the passage of a short period of time, given that the patients have been ill for many years. This argument is supported by TAPS results for a similar group after one year, where the control group who remained in hospital showed no change in clinical or social state over time.

4. Regarding the staff study; in view of the small sample size as well as the different grades of staff represented, it was decided to tape record the staff's expression of their opinions. In the absence of similar studies on staff, this open ended questionnaire will provide basic data on different types of staff attitudes, roles' and needs for preparation in order to work outside psychiatric hospitals. These data would help in developing a structured questionnaire that could be used in various community settings with different type of staff.

Organisation of the Thesis

This is a combined study of the discharge of long-stay psychiatric patients into the community, conducted through the patients, staff and the local residents. In order to facilitate the flow of material and for ease of understanding, it is presented here in three seperate sections as three individual studies, under the titles "Public Study", "Patients Study" and "Staff Study".

1. PUBLIC STUDY

PUBLIC PERCEPTIONS OF FORMER PSYCHIATRIC PATIENTS MOVING INTO THEIR NEIGHBOURHOOD

1. INTRODUCTION

1.1 RATIONALE OF THE STUDY AND THE QUESTIONS ADDRESSED BY THIS STUDY

In Britain, the emphasis of planning and policies in the area of psychiatric services is on treating psychiatric patients outside the psychiatric hospitals. Despite this, few attempts have been made to consult the community that patients are moving into. Moreover, attempts to study public opinions about community care have often been faced with resistance from both administrators and professionals alike. Consequently, the general public is now in the position of having to interact with former psychiatric patients as they move into their area without adequate preparation for what is going to happen. In recent years some sporadic attempts have been made to consult local residents and organise public meetings, but no formal efforts have been made to assess public attitudes and actively plan for educational programmes tailored to the public needs.

The government put forward recommendations in "Better Services for the Mentally Ill" (DHSS 1975), the Audit Commission (1986), Making a Reality of Community Care (1987) and the White Paper (1989) for changes in the provision of finance by social security, joint planning by health and local authorities, and appropriate staffing. However, nothing was mentioned with regards to preparing the community for patients' discharge with the aim of reducing the amount of social distance between the public and mentally ill people.

Planners assumed that change in treatment legislation need not necessarily be accompanied by change in public attitudes to those changes. Moreover, there is a pervasive belief that involving the public in planning community care and accepting former psychiatric patients as their neighbours could stir up public anxieties toward developing services in their area. However, this assumption has never been tested through empirical research, although the literature on public attitudes describes a wide range of public reactions.

Dear and Taylor (1982) indicated that public attitudes to mentally ill people and to their facilities are fundamental for successful deinstitutionalization, because they influence the patients' social integration in the community, and that the therapeutic effect of rehabilitation could be counteracted by public rejection.

Community care planners have tended to apply the results of public attitude studies in the past within the context of present policies. This may well be irrelevant because the concept of mental health, therapeutic intervention and the political climate

have changed in a way that is likely to affect current public attitudes. The consequence is that the important issue of the transition of care from the hospital to the community has been carried out with a relative neglect of public, patients' and staff requirements.

The role of the public in patients' readjustment in the community has been ignored in the process of phasing out psychiatric hospitals. Turner (1988) pointed out the importance of improving psychiatric services in order to gain public respect for community care and to reduce the stigma of mental illness. Lemkau (1968) and Furnham and Rees (1988) considered that public acceptance of mentally ill people in the community could determine the success or failure of community services, determining the type of symptoms that could or could not be tolerated.

Studies of public attitudes indicated that the stigma of mental illness could have a deleterious effect on former psychiatric patients. Ross (1962) pointed out that society should still be prevailed upon to play a major part in their rehabilitation and coping with life outside the hospital. Green et al (1987) indicated that a change in public attitude should be achieved before the political and professional trend toward deinstitutionalization of mentally ill and implementation of community care.

Some believed that discharging psychiatric patients into a convenient place in the community would allow hospital closure. Lamb (1979) pointed out that this is only creating small institutions in the community. Historical evidence on community care predicts frequent relapses of the mentally ill, which lead to more disappointments and a sense of failure and mistrust in the authority. Green et al (1987) added that schemes for reintegrating patients into the community will succeed only if the community wishes them to, and has the confidence and the skills to show care and concern for mentally ill.

Some planners believe in the adoption of the concept of "normalisation" in shifting the services into the community, namely persuading former long-stay patients to carry out "normal" roles. This should make the public perceive mentally ill people as "normal", and consequently, their attitudes should change. Some authors (Holmes,1968; Pryer et al, 1969; and Hazleton et al; 1975) consider that education of the public is necessary in order to change their attitudes. Simple contact of the public with mentally ill people is unlikely to induce positive attitudes. Wahl and Lefkowits (1989) demonstrated that corrective information could also counteract the stigma attached to mental illness.

Reviewing the literature on public attitudes toward mental illness has revealed inconsistent views about public acceptance of mentally ill people, as well as identifying the factors that might affect acceptance. While Star (1955) and Nunnally (1961) found that the public held a negative attitude, Crocetti and Lemkau (1962) reported greater public recognition for mental illness and more acceptance for closer social contact with mentally ill people, as well as acceptance of home care.

Sir George Godber (1964) postulated that change in public attitude is as necessary as change in professional approach and skill in producing development in community

mental health services. Gatherer and Reid (1963) noted that community attitudes not only influence people's recognition of mental illness, as well as the demand for services, but also the public image of a disease can influence behaviour towards it.

Furnham and Rees (1988) noted that in Britain, people accept the "psychosocial model" of mental illness. This view (Rabkin, 1974) might bring public acceptance of mental illness, but also could have an opposite effect if an increased number of acutely disturbed people were discharged into the community. She suggested the importance of studying the effects of this increase on the beliefs of the British public, which she described as the "Lay Implicit Theory" concerning schizophrenia. Furnham and Rees suggested that investigating lay beliefs about mental illness not only helps in the understanding of people's perceptions of mental illness, but also can be used as a measure of success or failure of mental health education programmes.

A review of the literature on the American (Dear & Taylor , 1979 & Smith, 1980), Australian (Walkey et al, 1981 & Olmstead & Durham, 1976) and the Italian (Bollini & Mollica, 1989 & Visotskey, 1987) experience on community care, demonstrates that social acceptance of the mentally ill is positively related to exposure to phasing out psychiatric hospitals. Additionally, participating in the process of community care may lead to the community placing more trust in the effectiveness of such a system. For example, in Italy Bollini & Mollica (1989) and (Visotskey, 1987) showed that the shift in the services was helped by the change in public and professional attitudes towards the mentally ill that favoured less restrictive treatment. Rotelli (1988) added that society at large (patients, the local community and politicians) in Italy was involved in the change.

Studies on the factors that might influence patients' adjustment to the community offer valuable clues for a comprehensive study on public reactions towards patients moving into their neighbourhood. For example, Sister Loretta (1965) suggested that attitudes do not change by information alone, but by involving the public emotionally and helping them to gain insight into their attitudes, for instance, why they fear mentally ill people, and that anxiety is natural. In this way they can achieve an intellectual awareness of a problem. Taylor et al (1979) showed that attitudes toward mental illness correlate positively with the presence of mental health facilities in the area. One can also predict the reactions toward a mental health facility by finding out the attitudes toward mental illness beforehand. Similarly, the type of neighbourhood was also investigated by Segal and Moyles (1980).

British experience with public contacts with former psychiatric patients has so far indicated that the public object to patients' disturbed behaviour in public places (Goldberg et al, 1985). One would anticipate an increasing occurrence of such objectionable behaviour during patients' contacts with the public, with the rising number of discharged patients who are severely handicapped by their illness. This brings to light the crucial and double role staff members need to play in patient's rehabilitation and readjustment in

the community, and in facilitating public acceptance of them. This underlines the staff's need for preparation to equip them with professional and managerial skills.

The NHS Management Board has issued a statement on psychiatric rehabilitation and care in the community (1987) in which they discussed the needs of the present psychiatric hospital population, who have continuous clinical and social problems. The need for rehabilitation depends on a comprehensive assessment of patients' disabilities and assets at different times, as well as skilful co-ordination between occupational, residential and leisure-time provision. These rehabilitation plans should be adequately organised before any large scale transfer to the community. The Management Board anticipated that the problems arising during transitional periods in community care would be: 1. staff training, 2. patients' preparation, 3. rehabilitation needs 4. Long-term needs of patients in the community. They presented an example of conflicting views of the types of staff needed to care for the patients in the community. While the Health Authorities accepted the fact that many discharged patients will require professional multi-disciplinary support, the Department of Social Security assumed that all former patients will be cared for by residential officers and care assistants.

More recently, deinstitutionalization has come under criticism from people within the profession. Patients' quality of life, and preparation for adequate professional support are the main issues that need to be investigated. Neglecting these important issues could cause public confusion and mistrust in professionals as well as policy makers. This view was expressed by Bachrach (1988) who considered that deinstitutionalization was basically a political, not a clinical solution to service delivery problems. This resulted in many of the chronic mentally ill being deprived of adequate clinical care. She held that the homeless mentally ill were the responsibility of the politicians as they establish rules and regulations for planning services for the mentally ill.

There is a wide gap in the knowledge about public perception of simple facts about mental illness and of mental health services. This lack of knowledge could lead to the persistence of stereotyped ideas about mental illness and consequently encourage prejudice and rejection of the mentally ill and the continuation of stigma, if a passive neglect of the whole problem remains. The danger arises when one allows the false public image to continue, while moving ex-psychiatric patients to the community and closing psychiatric hospitals, which historically existed to protect the public from the dangers of the mentally disturbed. This could lead to myths being elaborated, spread and strengthened, while the challenge to community care and mental health education would also escalate. Miller (1979) suggested the importance of providing an opportunity for the public to discuss the behaviour of emotionally disturbed persons. This could help various groups as well as professions to plan and organise the help and support that might be needed. It is unjustifiable to ignore the public role in the planning and success of community care on the grounds of difficulties or complexity.

One could conclude that the criteria for success of community care include: change in attitudes towards the concept of mental illness, acceptance of community responsibilities towards long-term ex-psychiatric patients, services that are equipped with well-prepared and efficient staff, and continuous successful rehabilitation.

The theoretical foundation of this study is that "labelling of mental illness" rather than patients' behaviour plays an important role in public attitudes. One could argue that beliefs and preconceived ideas of local residents about mental illness influence their opinions, and they will behave accordingly toward mental health facilities and former psychiatric patients moved into their neighbourhood. An implicit assumption of this study is that positive staff attitudes towards working outside psychiatric hospital as well as former psychiatric patients' behaviour will affect public reactions positively and vice versa.

In the light of the previous discussion, research is urgently required to investigate public attitudes and knowledge of mental illness, otherwise there will be a continuing danger of planning the mental health services in complete ignorance of influential factors involved.

The results of the present research will help in understanding whether community care actually fosters greater acceptance of mentally ill people or not, or whether current services are negatively sensitising people toward the mentally ill. It is also an attempt to help staff members and former psychiatric patients to examine messages that the public receive from various sources to understand the complex forces which influence prejudice and so lead to discrimination .

Identification of public perceptions by this study will provide baseline data for future studies. The study will describe patients' and staff needs, as well as problems before and during the transition period. This study will address the following questions:

1. What are the public perceptions of mentally ill people?
2. What are the public opinions about community care?
3. What sort of preparations do the public need before mentally ill people move to their neighbourhood?
4. What are the public reactions toward opening psychiatric services in their area?
5. What are the staff opinions about psychiatric patients' needs during the transition period?
6. What are the staff members' needs during the transition period?
7. What are the changes in patients' conditions during the transition period?
8. Factors that might influence success or failure in looking after the patients in the community.
9. Strategies that could be employed to provide professional support for patients, staff and the public.

OVERALL OBJECTIVES OF THE STUDY

It is postulated that local residents' reactions towards ex-psychiatric patients result from their knowledge and experience of psychiatric patients. For example:

1 Local residents' negative attitudes towards psychiatric patients will influence their identification of former psychiatric patients.

2. Certain characteristics of ex-patients will influence the responses of the local residents to them.

3. Local residents will be more negative in their attitudes towards psychiatric patients than they are to other disadvantaged groups (socially deviant groups) e.g. mentally handicapped, old age pensioners, vagrants, and unemployed.

4. Local residents will show more negative attitudes towards former psychiatric patients if they already know somebody who is a psychiatric patient.

5. Local residents will show a change in attitude towards former psychiatric patients as a result of a range of personal and social contacts with them as neighbours.

6. Local residents' psychosocial characteristics will influence their attitudes toward former psychiatric patients.

7. Local residents approached by the staff will show more positive attitudes than those who were not approached by the staff.

It was not expected to be possible to determine precisely which of these factors were operating to influence the local residents' attitudes towards ex-psychiatric patients living in their neighbourhood. Therefore, coming in contact with ex-psychiatric patients was considered the common factor which might influence the local residents' attitudes over 6 months. However, there is no guarantee that there are no ex-psychiatric patients living independently in the control group area.

1.2 THEORETICAL BACKGROUND OF THE STUDY

Many of our attitudes involve stereotypes which may be simplistic and overgeneralized. Mentally ill people are particularly likely to be subject to stereotyping. In the process of stereotyping, our experiences of a few mentally ill people lead us to expectations about other mentally ill people, and expectations could colour subsequent perceptions as well as eliciting the expected behaviour. Jones (1982) stated that one consequence of stereotyping processes is that they reduce our need for further explanations for causes and behaviour of mentally ill people and difficulty in diagnosis.

Townsend (1979) argued not only that the layman overgeneralizes and oversimplifies, but that mental health professionals, especially psychiatrists, might do so more readily. There is a temptation to decide on a diagnostic category and then 'make the symptoms fit', rather than preceding the other way around. Kendell et al (1971) selected matched groups of British and American psychiatrists who viewed videotapes of patient interviews. Agreement was found on diagnosis of patients who exhibited psychotic symptomatology, however, there was serious disagreement on non-psychotic disorders. A much higher proportion of American psychiatrists tended to diagnose schizophrenia (69%-85%) compared with the British (2-3%). The authors concluded that individuals who tend to be labelled psychotic are characterised by: 1. involuntarily receiving treatment, 2. treated with ECT and major tranquilizers, 3. have their normal rights and duties suspended.

Parsons (1951) pointed out that a person enters the 'sick role' when his behaviour is perceived to be illness. It is considered as a normative social position, but one which creates abnormal roles and regulations. The sick person is exempted from normal roles, but takes on a set of responsibilities such as, seek treatment and getting well. The Parsons model fits in relation to long-stay patients. Even though psychiatric patients in the hospital seeking treatment, they are excluded from their normal roles and expected to continue to do so. Hospital closure does not exempt them from 'sick role'.

Barton (1976) considered that long stay patients' behaviour is a manifestation of their institutional behaviour. The assumption underlining the labelling theory is that once a diagnosis of mental illness is made, the label [metaphorically] sticks, so that the person experience great difficulty in returning to normatively valued social role. The medical diagnosis itself carry with it the definition of behaviour.

The terms 'chronic' 'long stay' do not describe the patients mental state only, but also the way the person copes with everyday life. Labelling theories have undoubtedly been significant in the care for the support policy. Negative attitudes and beliefs about mental illness lead people to think that someone who is mentally ill does not have similar needs and feelings in most respects to "normal" people. When a person is labelled as

mentally ill it is taken to indicate that the individual needs protection from everyday risks in the community. Such paternalism may lead to restrictions on independence.

In this section various theories and concepts that attempt to explain public attitudes towards mental illness will be presented briefly:

1.2.1 Stereotype

This concept is based on the psychoanalytic view of individual intra-psychic defence mechanisms, in that it supposes that within an individual and a group, those qualities least desired and valued will be denied and projected onto a vulnerable and susceptible scapegoat to maintain integrity and credibility.

Stereotypes are a set of traits that are used to explain and predict the behaviour of socially defined groups. Miller (1982) discussed the origin, definitions and the development of stereotyping in detail in his book "In The Eye Of Beholder". He considered stereotyping to be a process of social cognition of socially defined groups.

Scheff (1966) considered that the stereotype of insanity is learned early in childhood, and colours ordinary interaction. According to Scheff, the stereotype of insanity is an unreasoned fear of the mentally ill which makes the public unwilling to take risks that would routinely be accepted in ordinary living.

1.2.2 Location theory

Dear and Taylor's (1982) "Location Theory" places emphasis on the importance of the social and political processes underlying the location of a public facility. They found that accessibility of a facility for potential users has direct bearing on public attitudes, being likely to lead to acceptance by or at least indifference on the part of the host community. If the facility is inaccessible it generates negative external effects.

1.2.3 The medical model

The other important theoretical concept concerning social reactions to mental illness is that of the medical model. The medical model postulates that deviant behaviour is a manifestation of a disorder of the central nervous system. Symptoms result from a combination of physiological, and genetic factors and the patient's tolerance for stress. Treatment is based on the diagnosis of a mental illness and is dominated by somatic treatments, including pharmacotherapy, electroconvulsive therapy and, occasionally, psychosurgery. Siegler and Osmond (1976) believe that the medical model fulfils two functions, first treating the mentally ill and second, viewing the illness as a disease helps to remove some of the social stigma.

1.2.4 The social model

By contrast, the societal reaction or labelling theory of hospitalisation primarily focuses on the reactions of others rather than the deviant act itself. The mentally ill person with economic and social resources will be able to delay psychiatric treatment and hospitalisation unless they are seriously disturbed, while mentally ill people without those resources will be hospitalised even though they are not seriously ill.

Goffman (1963) described the stigma of mental illness as an attribute which is socially discrediting to the mentally ill person. He also noted that inherent in this description is the idea that the attribute is permanent, that it affects one's perception of the person as a whole, and that it is so important as to become the key distinguishing feature of the person in the eyes of others.

Becker (1963) discussed in his book "The Outsiders" the way in which society can contribute to the production of deviance within the individual. Scheff's theoretical contribution towards understanding popular conceptions of mental illness concerns deviancy theory or labelling theory. According to this theory, acts are labelled as 'deviant' when they violate the laws of social rule-bound behaviour.

Labelling/societal reactions theory makes a fundamental distinction between primary and secondary deviance (Lemert, 1967). Primary deviance constitutes those initial acts which challenge social norms. Secondary deviance occurs after a person has been labelled as abnormal, and identifies with the role of a deviant as a primary life style. Murphy (1976) defined secondary deviance as "negative feedback from others which reinforces and stabilises the behaviour that initially produced it".

A crucial development of this theory was made by Goffman in 'Stigma' by which he refers to an attribute of an individual that is 'deeply discrediting'. Without popular acceptance, the stigmatised person employs the role for 'secondary gain', for example in blaming his label as an excuse for lack of success.

Labelling theory proposes that social characteristics of the patients determine the severity of the societal reaction, independent of psychiatric condition. Scheff (1964) showed that social factors and not just psychiatric factors are important in mental hospitalisation. Linsky (1970) and Rushing and Esco (1977) found that the individual's resources are significantly related to legal status during hospitalisation.

Townsend (1979) added that the label attached to a person played a more important role in determining what qualities were attributed to that person than the person's actual appearance or behaviour.

According to labelling theory the processes of labelling a person as mentally ill are:

1. Under a variety of circumstances it is relatively easy to be labelled mentally ill.
2. The more social power a person has, the more likely s/he will be able to avoid hospitalisation or delay being channelled into a deviant role.

3. Labelling theory does not view individuals who are mentally ill as intrinsically different from persons who are not labelled so.
4. After the primary deviance is controlled, the more marginal the public attitudes are the more likely the person is to be channelled into a deviant role. Labelling theory postulates that once the individual enters a psychiatric hospital, it becomes tremendously difficult for the person to break out of his deviant status.

Goffman (1961) discussed the consequences of hospitalisation as: 1. it promotes acceptance of the mentally ill role. 2. in the hospital a lot of restrictions apply on the patient as part of treatment 3. defamatory and discrediting events are selected and recorded in the patient's case note. These events tend to become public knowledge, and to validate his mental illness.

Croceti et al (1972) reviewed literature on public attitudes towards mental illness from the basis of various theories of mental illness, and found that some models were useful in explaining some mental illness. It is unlikely that social deviancy theory will ever stand alone, and they concluded that virtually all the results pointed out to the need for multiple theoretical models for understanding the variety of mental illness.

In addition, Brockman et al (1979) analysed 22 studies about public attitudes towards mental illness. They found that the results of studies conducted by social scientists were more likely to show that the public attitude is negative, whereas studies by medical researchers studies tended to be positive. Regarding data collection technique, closed-ended interviews lead to positive results, whereas open-ended interviews tend to be negative. They also found that a small number of social distance factors were used throughout the studies. They warned against interpreting the results either positively or negatively as public attitudes are clearly complex and multi-faceted.

The study to be described is an experimental attempt to find out what the contemporary perception of mentally ill people is like. Although there are limitations to the theoretical conclusions that can be drawn from the research, the results will be discussed in the light of the various theoretical concepts presented in this section.

1.3 BRITISH PUBLIC ATTITUDES TOWARDS MENTAL ILLNESS

In this section studies carried out in Britain will be discussed. The purpose is to identify British public attitudes toward mental illness and mental health facilities, which could shed light on what has to be learned, expected and needed in the era of alternatives to hospital care.

One could argue that the decision to close psychiatric hospitals was originally a political one, and that the provision of community care has been organised and monitored by administrators. Psychiatric care in the community seems to have lost its psychological and professional atmosphere, a change which might affect the public concept of

community care. However, Mr. Dorrell, the Minister of Health, in his talk at a conference (1990) stressed that the principal responsibility for the implementation of community care, must rest with professionals-all personnel who are responsible for patient care. This decision could be crucial for engendering positive public attitudes towards community care. A positive public attitude is essential because, firstly, members of the public think highly of the NHS. Bosanquet (1988) indicated that the British public held high confidence and satisfaction in the NHS regardless of their political party or demographic characteristics. In a survey in 1987 Bosanquet showed that introduction of private health services had no effect on public attitude towards the NHS. Support for the principle of state health care, and the need to increase public expenditure, has become even stronger. However, dissatisfaction with NHS services (especially hospitals) has increased from 25% in 1983 to 40% in 1987. The public are satisfied with the professionals but dissatisfied with staffing, organisation and the ability to deliver services at an acceptable pace. The NHS is considered not only as part of the welfare state, but also as a political institution. He suggested that in order to carry out any reform in health care, public confidence should be restored.

Secondly, recent government reports point to a new emphasis related to care within the family, The 1979 Report of the Royal Commission on the National Health Services, Griffiths' Report (1989) and the DHSS White Paper (1990), when discussing community care for the mentally ill, made it clear this is provided primarily by families or neighbours, with the support of the health and personal social services. As yet, no attempt has been made to actively involve the public in community care.

Thirdly, the British public fear mentally ill people and stigmatise them, and consequently the public has high expectations that the professionals will allay those fears (Royal College of Psychiatrists, 1987).

1.3.1 British public concepts of mental illness

Concepts of mental illness may be categorised according to on two different views, The first view (Rabkin, 1974) is based on the "medical model" which considers mental illness like any other illness. The second view is influenced by the "psychosocial model", and is based on primary prevention and early treatment in the community. Furnham and Rees (1988) indicated that in Britain, people accept the "psychosocial model" of mental illness. This view (Rabkin, 1974) might lead to public acceptance of mental illness. Psychiatric hospital closure in England could have the opposite effect if it brings into the community an increased number of disturbed people. Rabkin (1974) emphasised the importance of studying the effects of this increase on the beliefs of the British public about schizophrenia. Furnham and Rees suggested that lay beliefs about mental illness not only help in understanding people's perceptions of mental illness, but

also can be used as a measure of success or failure of mental health education programmes.

Crumpton and Wing (1965) asked normal and schizophrenic adults to give their conception of both normality and mental illness. The normal group thought of the normal person as admirable with many good qualities but still capable of acquiring some neurotic behaviours. The mental patient was conceived of as peculiar, different, pitied and feared but moral. By contrast the schizophrenic group appeared to have inconsistent ideas about the normal person, and viewed the mental patient as immoral and inconsequential.

The DSS White Paper (1975) 'Better Services for the Mentally Ill' pointed out that the DSS in 1973 considered the validity of community care without specifying its strategy. The White Paper recommended expansion of the local services with good links between different aspects of the services and with a multi-professional approach to planning of care. The Paper also recognised the importance of a steady increase in awareness that mental abnormalities are illnesses. It also viewed the key to progress to positive attitudes as being the recognition of mental illness within the context of the medical model. Furthermore it emphasised the need to stop isolating former psychiatric patients and considered the help of volunteers as part of the plan to alleviate patients' isolation. Again, Blumer (1986) considered that accepting mental illness as on a part with any other illness was a way of inducing positive public attitudes towards psychiatric services.

1.3.2 Mental Health education of the British public

In January 1957, the British Broadcasting Corporation (BBC) attempted to measure public attitudes by broadcasting a series of programmes called 'The Hurt Mind' for half an hour five times a week, dealing with various areas of mental illness such as causes, nature and treatment. The BBC also included panel discussions on aspects of treatment and the social consequences of mental illness. The programme was watched by about 5_ million people.

A survey was carried out on three groups of the population in the London area. The first group who had seen the series, the second group who had not seen the series and a control group (167) were invited to Broadcasting House before broadcasting the series, in order to complete questionnaires. Belson (1957) reviewed the BBC results, and found that the public had made a distinction between mental illness and insanity. There was unwillingness to accept former psychiatric patients in certain occupations, or to associate with them, and to avoid talking mental illness. However, there was a degree of expressed sympathy and concern. The educational programme brought about little change in viewers' opinions about mental illness. However, the viewers' information about mental illness increased, especially with respect to methods of treatment. The viewers' confidence in the professionals was found to have increased.

In 1958 Carstairs and Wing carried out a content-analysis of 167 questionnaire results and 1,267 letters written to the BBC by the viewers in response to the "Hurt Mind" programme. The results of 167 answers which were thought representative of the British public indicated that the mentally ill person was perceived as a madman, who cannot think, and is unpredictable, deluded and withdrawn. Treatment of mental illness was considered to be rest and kindness. Analysis of the letters revealed the following:

1. Requests for further information about mental illness such as causes of mental illness, and the relationship between neurosis and insanity.
2. Requests for advice about treatment, what needs to be done for a sick relative.
3. Suggestions for alternative therapies such as biotherapy.
4. Treatment in the community: the great majority of the viewers were concerned about the welfare of the patients in the community.
5. Stigma of mental illness: patients and their relatives wrote about prejudice against them.
6. Concern about General Practitioners (GP): many patients complained about the inability of their GP to understand and treat their condition.
7. Reactions to mental hospitals: some viewers praised hospital staff while others expressed dissatisfaction with the services.
8. Help for the mentally ill: two people offered help for the mentally ill.

Carstairs and Wing (1958) concluded that mental illness remained stigmatised and feared, and the public still lacked information. They suggested continuing education for the public.

The Ministry of Health in Britain (1961) identified a need for informal acceptance by the general public of the changing policy on mental illness, with an emphasis on care in the community and full participation by the mentally ill in the community. These policies emphasised the need for an input from social services as well as an increase in public tolerance. The Ministry of Health recommended that these could be achieved by a prolonged educational campaign aimed at imparting knowledge. The Ministry considered that a short-term educational programme could not be expected to achieve the desired results. However, this recommendation has not been implemented.

The Joint Committee of the Central and Scottish Health Services Councils Report (1964) described aspects of the technique of health education as follows:

1. Deciding which method is to be used depends on the circumstances.
2. Expert advice should be taken in planning a health education programme. Circumstances, aims, attitudes, counter influences, sources of support and relevant data should be taken into account.
3. Close contact is necessary between TV authorities and those responsible for health education. In order to gain support and make education relatively easy the people responsible for education should keep close contact with the media.

A political and economic planning survey (1961) showed that the public regard the health service as more important than any other services.

A Ministry of Health Report (1964) pointed out that mental health education should promote the principle that professionals are generally agreed on, as well as all research and measures designed to preserve a mentally balanced community and assist the community in recognising its responsibilities to psychiatric patients. The report added that local authorities should be aware of the need for the community to develop an understanding of the special problems of psychiatric patients and should incorporate the subject of mental illness in their general health education programmes. The National Association for Mental Health, a voluntary organisation formed in 1946 from the fusion of three bodies in the field of mental health, and the Scottish Association for Mental Health, organised a public education programme to learn about mental health as well as professionals in contact with the public. Even though there was evidence of improvements in public opinion about mental health, The National Association could not assess change in attitudes or identify factors that brought about change.

Gather and Reid (1963) believed that the care of mental disorders in the community will develop only as the result of public appreciation and education. Public attitudes will be decisive in the achievement of community care. This view was emphasised in the Ministry of Health report on plans for the development of health and welfare services of local authorities (1963) 'The development of mental health services - should in turn increase the public's understanding of mental disorders and their sympathy with what the services are trying to do. Thus the expansion of the services and the growth of public appreciation of their objects must go hand in hand'.

Gather and Reid (1963) identified the main difficulties related to public education, as:

1. Lack of precise knowledge of present attitudes by the mental health planners.
2. The media disseminate non-systematic sporadic information about community care - this information is unbalanced, emphasising mainly the hazardous side effects of community care.
3. Lack of expertise in community care.
4. Poor community facilities to replace old institutions.
5. The development of community care coincided with the cut back in health facilities and privatisation of the NHS.

In 1962 The Northamptonshire Mental Health Project was sponsored by the Duke of Gloucester. The project was a joint planning enterprise between the County Health Department and the Northamptonshire branch of the British Red Cross Society. The main aim of the project was a mental health education campaign in order to facilitate community care.

The strategy was to alter public attitudes towards mental illness by:

1. increasing awareness of mental health problems,

2. increasing public knowledge about aetiology, and
3. treatment services for mentally ill people.

The Project was designed to detect change by assessing change in public attitudes before and after the mental health education programme. The project lasted for one year and involved the Press, radio and television in the education campaign. The sample size was 938 on the first occasion and 968 and on the second occasion. The team concluded that there was no indication of change in public attitudes or knowledge about mental illness. However, Local Authorities gained knowledge about public attitudes to mental disorder. The results revealed that there was a wide gap in public knowledge of simple facts about mental illness and of mental health services. The public viewed the physically handicapped more favourably than the mentally ill.

Limitations of the education programme were:

1. attempting to reach a large proportion of the population made the campaign more difficult.
2. the section of population with deeply fixed ideas were less inclined to regard mental disorder as being the patients' problem. The research team suggested that the existence of this group should be recognised, so that the development of mental health services should not develop too far ahead of public opinion.

Market & Opinion Research International (MORI) (1979) conducted a survey between 16 and 20 of August. Objectives of the research were to identify:
1. beliefs about causes of mental illness, 2. sympathy towards mental health problems, 3. experience of dealing with mentally ill people, 4. knowledge about curability of mental illness. The study sample was 1968 subjects in 165 constituencies in Britain. The sample was an interlocking quota sample with controls for sex, age, social class and geographical location. Data were collected by face to face interviews in the respondents' homes. Mental illness was recognised as one of the biggest health problems in Britain.

Regarding attitudes toward mental illness, the majority of the respondents (81%) agreed with the statement "most people are embarrassed by mentally ill people". By contrast 60% disagreed with the statement "I am embarrassed by mentally ill people". A few people felt a personal responsibility to help. The common causes of mental illness identified were worries (77%), this included: problems at home (17%), at work (14%) and money (14%). Other causes were: marital problems, weakness of character, heredity, physical structure of the brain, problem in bringing up children, old age, overcrowding and noise. Regarding contact with mental illness: 3% (1_ million) of the population said that they had suffered a mental breakdown or have mental handicap and 34% (13 million) indicated that they have relatives who suffered from mental illness or mental handicap. Mental illness was considered by 40% of the respondents the most difficult illness to deal with (more difficult than cancer, multiple sclerosis, epilepsy, blindness, arthritis, polio, heart disease, deafness and diabetes). Even though mental

illness was seen as a serious illness, it came low on the list of preferred charities. By contrast mental handicap was considered more deserving. Regarding treatment, 56% considered that mentally ill get worse treatment than physically ill people. Although 59% believed that people could recover from mental breakdown, 56% said that few or none of the mentally ill could be cured, compared to 17% who thought that the mentally ill could recover.

Levine (1972) compared public attitudes in Britain, Czechoslovakia and West Germany using the Opinions About Mental Illness Scale (OMI). The objectives of the study were to discover the effect of social and political climate on attitude toward mental illness. The subjects of the study consisted of students, physicians, nurses, and police from each country. The results showed that the British and Czechoslovakian samples were similar in their beliefs about causes of mental illness and mental hygiene in general, but differed significantly on the role of society toward the mentally ill. The author explained the difference between the two countries' in terms of their social and political differences. The West Germans scores were closer to the British scores especially with the student samples, but the physician sample's score were closer to the Czechoslovakians. Although there were differences between the groups due to occupation and age these were overshadowed by the differences between countries. He concluded that attitudes toward mental illness are part of the individual's general orientation to social and political issues, rather than stemming solely from their concepts of mental illness.

Locker et al (1979) studied public reaction and opposition to a hostel for the mentally handicapped opened in central London. A random sample of 271 individuals living in the streets surrounding the hostel were interviewed. Over 45% of the respondents knew about the hostel prior to the survey, information about the hostel being received informally through relatives and friends. Favourable attitudes about the hostel were expressed by 61% and only 14% of the interviewees expressed negative views. Only 7% had taken action in an attempt to stop the hotel opening. Over half, 54%, thought that the hostel should not be opened without public approval, while 40% said that they were inadequately informed. The researchers concluded that opposition to the hostel was not widespread. Factors significantly affecting the respondents' opinions were previous knowledge about the hostel and understanding of the term 'mental handicap'.

Richards (1982) carried out a random survey in Bristol to identify public views of mental illness. A hundred subjects of varying ages and occupations answered a questionnaire. The results showed that 42% knew somebody with mental illness, 32% agreed that nervous breakdown is a form of mental illness and 6% thought that all mentally ill are violent. Mental illness was considered an illness by 71%, 7% were not sure and 4% thought that mental illness was due to possession by evil spirits. Regarding the prognosis of mental illness, 78% said that it can be cured, while 20% thought that

patients who were likely not to become better should undergo some form of euthanasia. When asked about their opinions of former psychiatric patients moving into their neighbourhood, 53% did not mind, 7% objected and 35% abstained. When asked if they thought that the value of property would decrease 52% agreed. More than 50% of the subjects had not thought about mental illness before answering the questionnaire and 90% said that the general public should be informed about mental illness.

Nieradzik and Cochrane (1981) studied factors that might influence public attitudes toward mentally ill people. A random sample of 108 subjects from the general public in an urban population in the Birmingham area participated in the study. The sample consisted of 56% female and 44% male and their ages ranged from 16 to 75. The respondents were asked to rate on a 7-point social distance scale, three hypothetical people: one displayed normal, one schizophrenic and one neurotic behaviour. The scale was adapted from Kirk's scale (1974). The results showed that attitudes towards the mentally ill were influenced by variables such as: severity of the illness, age of the respondents, the presence of a diagnostic label, and non-deviant behaviour. Patients who responded to encouragement from others and actively accepted treatment were more likely to be perceived positively than patients who rejected treatment and help from others. They concluded that negative public attitudes were not related to social class as measured by occupation.

Hospital closure raised the concern that psychiatric patients in the community might lose their social networks established in the hospital and feel isolated. One could argue that in London, as in many big cities, people maintain very few contacts and generally feel isolated. Allen (1979) carried out a small survey in London about working class friendships, with the finding that they have very few friends or no friends at all. Relatives dominate working class friendships and friends dominate middle-class networks. Relatives outnumbered friends as a source of support during illness and bereavement. MORI (1982) surveyed relationships with neighbours and found that 9 out of 10 considered their neighbours friendly. Almost everybody knew some of their neighbours by name: 2% knew no one, 3% knowing one and 50% knew 11 or more. Two out of 3 visited neighbours for a chat, while nearly half of the respondents exchanged visits with their neighbours. Relationships with neighbours were a mixture of friendliness, reserve and sometimes aggression and mistrust.

Results of the studies that deal with psychiatric patients' social networks showed limitation in their size. This might result from problems in defining meaningful relationships for the patients. Willmott (1986) considered that friendship is very difficult to define: there is no agreement about what a friend is, or about how the relationship is to be distinguished from others such as colleague or acquaintance. There is a problem - people define friends differently. A general definition is that they are non-relatives, with whom we have a continuous relationship based on social contacts and on mutual help

when needed, associated with some degree of affection and emotional attachment. He noted that people in advanced societies choose friends relevant to family, occupational and social background. Friendship is based on mutual attraction and enjoyment of each other's company, rather than the concept of social exchange.

1.4 PUBLIC ATTITUDES TOWARD COMMUNITY MENTAL HEALTH FACILITIES:

Cooperation of the public with psychiatric treatment depends on the availability of facilities, that is to say if the treatment of psychiatric patients is in institutions away from normal life in the community, the public will have little knowledge about mental illness and poor acceptance of the sufferers. On the other hand, if the public believe that the goal of psychiatric treatment is to maintain former patients' social adequacy, and their acceptance by the community, the public will be more likely to participate in their socialisation.

Some studies have examined public perceptions of mental health facilities, for example Elinson et al (1967) investigated the public image of mental health services in New York City. The public suggested services for rapid assistance, such as a telephone information service and drop-in-centres. Some viewed mental hospitals as being like prisons. Others considered the quality of psychiatric hospital care as similar to the quality of care in the general hospital. Ninety percent wanted the government to spend more money on mental health services.

Bowen et al (1978) assessed community attitudes toward a family care programme using a postal questionnaire. The respondents were generally optimistic about the chances of recovery. Respondents with no children were more receptive to the idea of family-care programme, while those with children were highly ambivalent. With regard to the type of neighbourhood, Segal and Moyles (1980) found that conservative middle class communities were most likely to exhibit extreme negative reactions toward former psychiatric patients. Liberal, non-traditional neighbourhoods were generally accepting. Placement of sheltered-care residences in liberal, non-traditional and conservative working class neighbourhoods could facilitate social reintegration.

Taylor et al (1979) conducted a survey in Toronto of 1,090 respondents in two communities with and without mental health facilities in their neighbourhood. They indicated that public reactions varied according to three factors, the character of the local neighbourhood, the nature of the facility, and the attitudes toward mental illness of the general public. In addition, the researchers analysed these attitudes on the dimensions of authoritarianism, benevolence, mental hygiene ideology, and restrictiveness. Their

results showed that public attitudes are more important in predicting public reactions than the characteristics of the neighbourhood. In general public attitudes were positive. Even though a small number of the local residents knew about the presence of mental health facilities in their neighbourhood, there was minor vocal opposition. Loam and Egan (1990) carried out a random survey in seven towns/villages in Mid-Downs, England using a 15-item questionnaire about psychiatric hospitals. They interviewed 308 members of the general public. The results revealed that 71% had heard about hospital closure and 18% were in favour of closure. Treatment of psychiatric patients within general hospitals was recommended by 34%. Overall, 91% supported the need for small residential settings with workshops and supervision. Special arrangements for former psychiatric patients were suggested such as 'a large town', 'close to the shops', 'near the buses' and 'in a residential area'. Regarding the type of treatment, 60% preferred treatment at home (depending on the severity of the mental illness). With regard to caring for the patients in the community, in small towns 13% expected relatives to be the main carer, while in larger towns 74% expected professionals to look after the patients in the community with a variety of mental health facilities. They concluded that the public supported community care in conjunction with psychiatric hospitals. Loam and Egan (1990) suggested that the public needs reassurance that the mentally ill will not be left on the street and there will be enough facilities and carers to look after them.

1.4.1 Factors Affecting Stigma of Mental Illness

In order to provide adequate and appropriate services in the community, and prepare for the necessary intervention to overcome public intolerance effectively, it is crucial to increase our understanding of the nature of factors determining public attitudes towards the mentally ill.

In this section, factors determining public attitudes as they have been identified in the literature will be discussed.

1.4.1.1 Neighbourhood Type:

The notion that various neighbourhoods to which psychiatric patients would move will react differently to the mentally ill has been recently investigated by Segal (1980). They found that the most adverse reactions were common in conservative middle class areas. In contrast, liberal, non-traditional and conservative working-class populations showed a moderate adverse reaction, and promoted social integration as perceived by staff members of mental health facilities. The considered that moderate negative reactions acted as constructive concern rather that outright hostility, and stimulated the staff to promote social integration. It seemed that liberal, non-traditional and conservative working-class neighbourhoods were more accepting and encouraging of

patients to integrate in their area. They concluded that strong community adverse reactions were not all easily measured, unidimentional phenomenon, but rather had a variety of expressions and differentiating effects on the patients. The researchers pointed out that even the accepting environment was mixed in its reactions. They suggested that any community regardless of how tolerant it is for mental illness would suffer and its resources would be exhausted. Gelb (1980) concluded that the community's political values, socio-economic level and its past experience with mental health facilities might affect attitudes towards neighbourhood mental health facilities or former psychiatric patients.

1.4.1.2 Ethnocultural variables

Another variable identified that determines public attitude is the ethnocultural background of the respondents. It could be anticipated that the predominant ethnicity of a community to which a patient is going to be discharged is important in influencing patient adjustment to the community and for the degree of support the community facility could provide for the local residents.

Ramsey and Seipp (1948) showed that ethnic communities with close family ties recommended family care for the mentally ill but showed negative attitudes toward mental health personnel who did not belong to their ethnic group. In addition, Crawford et al (1960) found that blacks were less accepting of the mentally ill than whites.

Moreover, ethnic minority groups showed differences in their perception, knowledge and reported incidence of mental illness. Fournet (1967) compared a French Catholic group with an Anglo-Saxon Protestant group in Louisiana regarding their attitudes, perception, knowledge and reported incidence of mental illness. Using cluster analysis, 200 adult members of households were interviewed using the Opinion about Mental Illness Scale (OMI) and three case descriptions followed by two open-ended questionnaires regarding the problem and treatment of the case described. The results indicated that the two communities differed in their attitudes. The Anglo-Saxon community was more negative in their attitudes toward the mentally disturbed than the French community. No differences were recorded in the knowledge and perception of mental disorders in the two communities. Blacks in both communities were found to be more negative than the whites: few differences were found between them regarding their ability to identify disturbed behaviour but whites were more knowledgeable than blacks about mental illness.

The acceptance of contact was considered a variable that indicated a positive attitudes among ethnic minority groups. Jalal et al (1978) found that Northern European females had the most positive attitude and did not reject contact with the mentally ill, followed by American-born males and females, while Southern Europeans were negative. Black females were the most negative ethnic group. Hendricks et al (1981) in a study of

public attitudes in Newhaven found that non-whites were generally as receptive as whites to mental health services. However, non-whites differed from whites in having a higher disposition to use the clergy as a source of mental health care. Overall, the poor, less educated and younger adult members of the community were the least disposed to use mental health services. The researcher explained black females' attitudes on the grounds that they already feel stigmatised as a minority and could not tolerate the additional stigma of mental illness. An additional explanation of the results was given in terms of the closeness of family ties; that is to say the closer the family ties the more positive the attitude toward a mentally ill person.

1.4.1.3 Characteristics of the respondents

Demographic characteristics such as age, sex, educational background, household and occupation were found to influence public attitudes. Generally it was found that older people were less tolerant than the younger age group. Higher social class was associated with more tolerance of deviance, including mental illness. Lower social class respondents preferred to have mental illness treated as physical illness and were more likely to consider mental illness as bad and serious.

Whatley (1959) concluded that respondents with poor education, low income and manual occupation were less favourable in their attitudes toward mental illness than those with better education, occupation and income.

According to Johannsen (1969) younger and better educated persons showed more appreciation for community services and revealed greater social compassion and responsibility for mentally ill people than older people who were less educated and came from rural areas. The latter tended to uphold puritan values and personal performance. They wanted to stay away from mentally ill people and felt less responsible for the social problems caused by psychological disorders.

Bowen et al (1978) mailed a questionnaire to residents within 35 miles from the hospital. Most of the 235 respondents considered that mental illness was caused by lack of physical health or improper nurturing rather than being a punishment for sins. Older respondents were more likely to consider mental illness as caused by nature, while younger group tended toward the nurture view. Regarding prognosis, older people were less optimistic than the younger groups and more accepting of the concept of family care. Respondents with no children at home were more accepting of the idea of family care for psychiatric patients, while those with children at home were highly ambivalent. The younger age group considered that mental illness was caused by lack of parental love. 23% said that they would accept a mental patient as a boarder, while 31% said they would accept a mentally ill relative. People were more likely to accept a patient they knew than a stranger.

Leaf et al (1985) found that the younger age group were less likely to seek help for their mental health problems and faced more problems during their access to the services than the older age group. Subjects who indicated a high receptivity to services were more likely to actually use mental health services.

Link and Cullen (1986) showed that females students were more likely to have positive attitude than male students. Similarly, Parra (1987) showed that women were less likely than men to identify psychiatric symptoms in the city of Chihuahua, Mexico. Older women were less likely to identify depression as mental illness than younger women.

Leaf et al (1987) conducted interviews with two random samples: 3,058 young adults and 1,976 people age 65 and older in the city of New Haven. The questionnaire used was concerned with attitudes towards mental health facilities. They found that even though local residents held favourable attitudes toward the use of mental health services, many felt that their ability to access these services was limited. The findings also showed that females were more positive to mental health treatment and less concerned about the reactions of their families than male respondents. Older subjects were more receptive to community health services than the younger age group. Social class showed strong influences on attitudes towards mental health. The study also showed that attitudes and beliefs about mental illness were more important than the availability of mental health services in determining use of the services. Education was considered an important indicator of differences between public acceptance of mental health facilities in their area. Blizard (1970) studied social rejection of the alcoholic and the mentally ill in New Zealand. He used case histories and social distance scales. Age and educational background were found to have no effect, while previous contact with mental illness was significantly related to attitudes. He found that the more obviously deviant and threatening the behaviour, the more the rejection. Alcoholics and paranoid schizophrenics were identified as sharing the most disruptive behaviour.

Crocetti et al (1971) and Dohrenwend and Chin-Shong (1976) indicated that education and high income correlated positively with the ability to identify behaviour indicative of mental illness. Again, Freeman and Kassebaum (1960) studied the effect of formal education on knowledge about causes and prevention of mental illness using structured interviews. They found that respondents with more education believed that parents' attitudes towards children affect their mental health. Knowledge of technical psychiatric terms was related to formal education and the socio-economic status of the respondents. There was a significant correlation between knowledge of psychiatric vocabulary, and belief that patients could recover and willingness to visit a psychiatrist. The researchers concluded that there was no relationship between formal education and knowledge of causes and prevention of mental illness. They concluded that knowledge has little effect on attitudes.

1.4.1.4 Experience with mental health facilities:

A lot of emphasis has been placed upon the effects of the individual's contacts with the mentally ill on attitudes and the pattern of change. One could anticipate the effects of contact on stereotypes as that the behaviour of the stereotyped individual could correct or confirm a preconceived idea. Jones et al (1984) explained that the initial interaction between two persons was affected by the expectations each individual brought to the situation. Then, based on the first interaction, new experiences might occur and change might follow. The effects of the frequency of contacts was investigated by Triandis and Vassilious (1967) who used a semantic differential scale with two concepts "Americans in general tend to be" and the "Greeks in general tend to be". They carried out face-to-face interviews with six groups of American students with various degrees of contacts with Greeks. They found that the higher the level of contacts the more the Americans' stereotype towards the Greeks became clearer, while the Greeks' stereotype did not change with the frequency of contacts. In the case of absence of contact with a mentally ill person, members of the public would be affected by cultural stereotypes. Scheff (1966) and Gerbner (1980) added that members of the public who had little contact were thus influenced by these stereotypes and perceive mentally ill as dangerous. However, the underlying attitudes towards the mentally ill would bring the individual either to interact or to avoid interaction with them. Hall (1980) conducted a community survey in Canada to study attitudes toward mental illness and mental health facilities in a residential area in Canada. Respondents expressed sympathetic and benevolent attitudes toward mentally ill people. Lower class residents showed more positive attitudes toward mental health facilities than those of higher class. Positive attitudes to mental health facilities were associated with proximity to home, higher social class and urban areas. There is an important question of whether or not the frequency of contact would ameliorate stereotyping of mentally ill people. Few studies have been carried out on the differences between contact with relatives who are mentally ill and with non relatives.

1.4.1.5 Ethnocentrism

The idea is current that people who have a tendency to show negative reactions towards any individual who is different from themselves, would show negative reaction towards mentally ill people, regardless of their illness. The phenomenon of rejecting anything that is different was defined by Sullivan and Adelson (1954) as ethnocentrism, using a tendency towards general rejection. Chesler (1965) reported a significant correlation between ethnocentrism and attitudes towards physically disabled people.

Mulford (1968) interviewed 126 randomly sampled household members in an Iowa community, as well as 15 members of the local Mental Health Association as a control group. The objective of the study was to identify whether or not people who reject racial and ethnic out-groups are likely to reject mentally ill people. The results

revealed that ethnocentrism and stigma of mental illness were found to be significantly correlated.

1.4.1.6 Characteristics of Patients that Influence Public Attitudes

The literature on community care shows that the public stereotype of the mentally ill patient comprises unpredictability, dangerousness and lack of accountability.

Star (1952) found that only the most extreme forms of mentally ill behaviour were recognised by most people. She stated that 'There is a consistent tendency to belittle the serious and deep-seated nature of neuroses and emotional disturbances other than psychoses, and an equally consistent tendency to exaggerate the seriousness of psychoses. The neurotic is looked upon with moral disapproval; the psychotic, as dangerous'. Again, Nunnally's results (1961) supported those findings. He suggested that unpredictability was found to be the main reason for negative public attitudes. Unpredictable behaviour was seen as frightening and disruptive, which led to rejection and avoidance. In addition people believed that the mentally ill are more likely to be aggressive than others. This fear was the reason for people's concern about dealing with the mentally ill.

Similarly, Hazleton et al (1975), found in a California community survey that only 17% of the subjects agreed that mentally ill people were not dangerous. While, Linsky (1970) who studied the medical records of 14,304 patients admitted for the first time to the State Mental Hospital in Washington. There was a tendency for the community to isolate patients who were non-white, deviant, and low in social class, and patients who lacked close social ties.

Severity of the disorder and bizarre behaviour were more likely to be identified and rejected than less abnormal behaviour (Phillip, 1963 and Board, 1971). If "serious" behaviour which threatens the person's social and psychological security is the most likely to provoke people's antagonism then, if psychiatric patients took a constructive role and were more able to look after themselves public attitudes might shift to being less negative. Nieradzik and Cochrane (1981) studied the effects of the alternative non-deviant role on public attitudes towards the mentally ill. They used a social distance scale and three vignettes describing normal, neurotic and schizophrenic behaviour of three people with the normal role label of 'gifted painter, bank clerk and no role at all. These were presented in the form of a questionnaire to 108 subjects from the general urban population. They concluded that attitudes towards mental illness change with the availability of alternative roles for the mentally ill.

1.4.1.7 Recidivism

Studies published after 1960 found a high rate of arrests among discharged psychiatric patients compared to members of the general public. Steadman and Cocozza (1978) discovered a strong relationships between criminal records and admission to

psychiatric hospital. In addition, the general characteristics associated with the label and stereotype of mental illness are violence and threat to children; hence the public in general might associate mentally ill people with criminals.

Schwartz and Schwartz (1964) pointed out that there is a general concern that mental patients should not be held morally or legally accountable for their disturbed behaviour, especially among people who hold in the medical model of mental illness. Rabkin (1980) found that patients were less likely to be rejected by people of similar socio-demographic backgrounds than by those who perceived them as different. She suggested that patients' social status, income, ethnic group and degree of community involvement as well as mental state could influence public attitudes. Rabkin (1980) found that physical symptoms were more acceptable than bizarre symptoms which were inexplicable and mysterious such as hallucination or self-mutilation. Families more likely to hospitalise relatives whose behaviour were socially embarrassing than those who were not noticeable.

1.4.1.8 The Media

Nunnally (1961) studied the effects of the media on public attitudes toward mental illness. The results revealed that information from the media would seem more crucial to the perception of the element 'criminally insane' than to the mentally ill. Since the number of people who are appropriately called criminally insane are so few and hence unlikely to be encountered, this indicate that people formed their attitudes from the media. Similarly, Wahl and Lefkowits (1989) studied the impact of a television film on attitudes toward mental illness. A film portraying a mentally ill killer was shown to 3 groups of university students. The first group was shown the film with a trailer reminding them that violence is not characteristic of mentally ill people. The second group was shown the film without the trailer. The third group viewed a film not about mentally ill people. The responses to a scale measuring community attitudes toward the mentally ill showed that the first group was significantly less negative in their attitudes than the other two groups. This result supports the claim that the media could increase the stigma of mental illness and it also suggests that corrective information may counteract the effect of the stigma of mental illness. Rahav et al (1987) demonstrated that the media had influenced public perceptions of mental illness in Israel. On occasion it implied that mentally ill people were dangerous, illogical and bizarre. On other occasions it implied the opposite.

It could be concluded that public reactions toward opening of mental health facilities in their area were dependent on several variables such as type of neighbourhood, characteristics of the residents in the area, ethnocentrism, socio-economic background, the disturbed behaviour of former psychiatric patients and recidivism in the area.

1.4.2 Education of the public about mental health and community care

Previous attempts at public education:

Tershakovec (1964) considered that signs of a positive change in public attitudes are contact with mental illness and interaction with the professionals.

In order to combat the stigma of mental illness and its effects, sporadic public educational programmes have been established. It is hard to achieve change in attitudes and to measure those changes. A variety of procedures have been used to investigate generalisations about mentally ill people. Cumming and Cumming (1957) used a similar approach to Star (1952) in Canada in an attempt to evaluate public attitudes towards mental illness, then planned an educational programmes to remove stigma from mental disorders. The team concluded that their education campaign has caused anxiety and led to a firm rejection of their efforts.

The results of a national survey carried out by Horizon House (1975) to find out about methods to improve public reactions to the mentally ill recommended the following:

a. A public education programme could create a more positive image of the mentally ill.
b. The incidence of violent behaviour should be "downplayed".
c. Education of the media by the professionals to encourage them to present more favourable images of mentally ill.
d. Direct dialogue with the public on the problems and risks as well as the advantages of deinstitutionalization.
e. Proper care planning for preparation of psychiatric patients before and after their discharge.
f. Adequate community facilities in quantity and quality.
g. Research to monitor patients' progress in the community.
h. Avoiding accumulation in one neighbourhood of former psychiatric patients
i. Contribution of the mental health facilities to the welfare of their communities.

While some programmes tried to gain public acceptance of the medical model of mental illness, others were based on the belief that no one should be blamed or devalued because of his illness. It was found that most of the programmes aimed at conveying the following ideology to the public: 1. mental illness is a disease like any other illness, 2. it can affect anybody, 3. it needs treatment 4. it can be improved or treated.

Some researchers claimed that their campaign had achieved some effects upon the public notions of mental illness and greater awareness, such as Lemkau and Crocetti (1962); Crocetti and Lemkau (1963); Myer (1964), Bentz and Edgerton (1971). For example, Crocetti et al (1972) claimed that the public has learned to recognise mental illness, accepts medical care as an appropriate treatment and places less social distance

between themselves and mentally ill people. However, other studies carried out at the same time showed little or no effect of their programmes to educate the public and change their attitudes, such as the studies of Nunnally et al (1961), Phillips (1963, 1964, 1966 and 1967); Husek and Bobren (1964); Sieveking and Doctor (1969); Tringo (1970) and Sarbin and Mancuso (1972).

The Joint Commission on mental illness and health examined factors that led to failure in changing public attitudes after a massive educational programme. The Commission's report (1961) indicated that unpredictable behaviour of psychiatric patients threatens the stability of the community and plays an important role in public rejection. In addition, unpredictable behaviour gave an impression of irresponsibility to the community. The report concluded that some patients rejected sympathy and assistance due to lack of insight into their condition. This rejection was interpreted by members of the community as rejection of themselves by the patients, consequently, the public withdrew their attention from the patients. As part of a vicious circle patients' explained public withdrawal as rejection of them.

Other programmes took a different view of educating the public. They took into consideration correcting the underlying rejection of the mentally ill. For example, Holzberg and Gewirtz (1963) developed a programme for public education called "companion program" in Connecticut Valley hospital. The underlying philosophy of their programme was that public rejection begins when patients consider their hospitalisation in the first place as a rejection by the their community and consequently they reject the community after their discharge. In return the community rejected them. The researchers suggested that in order to alter public attitudes, patients' attitudes to hospitalisation should be positive, accepting their hospital stay as beneficial to them so that they would feel that their admission was not because of community rejection. The researchers designed an experiment in which they recruited 39 university students to act as companions to hospitalised mentally ill people for an academic year. The objective was to develop a sense of companionship between the patients and the students. The students spent an hour weekly with the patients outside the hospital in various leisure activities of their own interest. In addition, the students spent another hour with the staff to discuss patients' problems, and to express their own anxieties. The control group consisted of 20 students who were matched with the study group but pursued social interests other than accompanying the patients. Both groups completed a 23 item questionnaire. The questionnaire was applied at the beginning and at the end of the academic year. The items of the questionnaire dealt with attitudes and knowledge about mental illness. The results showed a significant positive change in the attitudes and knowledge of the experimental group. The researchers argued that the intellectual and the motivational factors of the university students could have contributed to the positive changes.

1.4.3 Outlines Of Approaches To Mental Health Education Programmes For The Public:

Sister Loretta (1965) suggested that attitudes do not change by information alone, but by involving the public emotionally and helping them to gain insight into themselves as to the origins of their fear, and to know that anxiety is natural. She drew up a strategy which would involve the public emotionally :-

1. Breaking down the public into small groups which share basic similarities in needs or characteristics.
2. Disseminating information through leaders in the mental health professions
3. Various methods of education which demand active participation from the public, such as seminars or group discussions.
4. Providing opportunities for the public to interact with psychiatric patients. This direct contact can help in reducing fears of mental illness.
5. A total co-ordination of the media material disseminated by T.V., radio and press.

Similarly, (Holmes, 1968; Pryer et al, 1969; and Hazleton et al, 1975) indicated that education of the public is necessary to change their attitudes. Simple contact of the public with mentally ill people is unlikely to induce positive attitudes. Smith (1981) emphasised that true public acceptance of the mentally ill requires an active and personal involvement of community members with former psychiatric patients.

Wahl and Lefkowits (1989) added that corrective information could also counteract the effects of the stigma of mental illness. Nunnally and Osgood (1958) indicated that positive change in public attitudes occurs as a consequence of providing low levels of information to their subjects. However, positive attitude change at higher levels of education and information could be due to other factors such as intensive experimental training.

The effectiveness of education programmes and media endeavours in changing public attitudes was examined by Sarbin and Mancus (1970). Holzberg and Gewirtz (1963) pointed out that the effects of a public educational programme using mass media to change public attitudes resulted in gaining public pity but their attitude remained one of ostracism and isolation from the mentally ill.

Health and Welfare (1963) reported that participation of the mentally ill in the community cannot be achieved without public co-operation. The report suggested that in order to accelerate public acceptance of the mentally ill, local health authorities should provide adequate services that would increase public understanding and appreciation of their roles, and consequently gain public sympathy toward the mentally ill.

Berkowitz et al (1984) designed a programme for educating families with schizophrenic relatives. They concluded that assessment of the value of an educational

programme should be based on change in attitudes rather than information gained. They added that to ensure change in attitudes, education should centre around the individual's needs. Lewin (1951) demonstrated that group discussions are better than lectures, personal interviews, or presentation by mass media in persuading people to change attitudes.

It can be concluded that it is important for the people responsible for public education to understand how public emotions could impede their receptivity to information. Ideally the public should achieve an intellectual awareness of a problem without feeling any emotional impact. Stigma can be reduced by informing the public. The more people are personally involved, the more responsibility they are likely to take for the mentally ill, and the greater are the chances of success.

1.5 POPULAR PERCEPTION OF MENTAL ILLNESS

In this section empirical and cross sectional studies in the area of public attitudes towards mental illness will be reviewed in order to identify the specific nature of the stigma of mental illness and the mechanism underlying attitude formation, as well as the public's perception of mental illness. Furnham and Rees (1988) suggested that knowledge of the lay beliefs about mental illness not only helps in the understanding of people's perceptions of mental illness, but also can be used as a measure of success or failure of mental health education programmes. Moreover, a number of authors have written that the process of labelling a deviant and the generalisations held about the types of deviants play a crucial role in determining the behaviour of the mentally ill.

1.5.1 Development of attitudes toward mental illness:

The 7th Report on social psychiatry (WHO 1959) discussed community attitudes in different countries and within various community groups. The working group found a wide range of population attitudes towards mental illness, extending from complete rejection to full acceptance as members of the community. Among these attitudes were: veneration, tolerance, pity, amusement, morbid curiosity, anxiety, fear, prejudice, repulsion and hostility.

Allport (1954) pointed out that the prejudiced person usually describes his negative attitudes in terms of some objectionable quality of the others. He argued that differences, if discovered, do not justify rejection. This notion was explained by Goffman (1968) who pointed out that anyone with a mental or physical handicap is stigmatised by society, which sees his functional behaviour as inadequate. Siassi et al (1973) showed that the sociological characteristics of psychiatric patients rather than their normative characteristics may be the significant variable.

Rhodes (1982) described the process by which the public express their rejection of the mentally ill person as occurrence or anticipation of behaviour associated with stereotyped conditions such as mental illness, alcoholism, drug addiction etc. Members of the public react by attempting to isolate, extrude, and exile the person through a variety of insulating and protective behaviours. The researcher added that public responses were similar, in spite of the diversity of the human taboo groups. Other explanation to the public believes about mental illness held by Downey (1967) who considered that public identification of mental illness reflected moral, mental and interpersonal explanations. Moral constitutes consideration of what is wrong and what is right, while interpersonal focuses on unacceptable behaviour in interpersonal relationships, such as chronic complaining, and being easily upset.

More recently, Furnham and Rees (1988) studied the lay theory of schizophrenia, using two 7 point scales about the common beliefs and causes of schizophrenia. The subjects were 120 members of the general public. Regarding common beliefs, the results showed that lay people perceived the mentally ill as potentially dangerous, erratic and unpredictable, and they expressed fear and apprehension. Concerning causes of schizophrenia, the results revealed that there is a link between explicit academic and implicit lay theories. The link was in the following areas: cognitive deficit theory of schizophrenia, stress and pressure, biological, genetic and brain damage causes.

A variety of research methods, including public opinion surveys, mass media content analysis, experimental studies and the semantic differential scales were adopted in order to investigate popular perception of mental illness. The literature showed inconsistent views concerning public acceptance of mentally ill people, and the factors that might affect their acceptance or rejection. While Star (1955); Cumming and Cumming (1957); and Nunnally (1961) found that the public held a negative attitude. The studies of Halpert 1969; Johannsen (1969), Edgerton and Bentz (1969) and Crocetti et al (1972) indicated better public understanding of mental illness and greater tolerance and acceptance of mentally ill people. The reasons for this mixture in attitudes discussed by Brockman et al (1979) who expressed doubts regarding the methods of data collection and interpretation of their results. In addition, Link and Cullen (1983) conducted an experimental study to determine how far respondents' answers reflected their real attitudes towards former psychiatric patients. They investigated public attitudes at four levels :

1. ideological level e.g. moral or expected response. 2. expressed attitude response. 3. attitudes that influence behaviour and 4. attitudes as acted upon. Their results support the hypothesis that when the individual in the vignette is labelled, ideal attitudes are more positive than attitudes as expressed. These in turn are more positive than an indicator of attitudes as acted upon and deep attitudes.

Studies that identified positive attitudes for example, Nunnally et al (1961) Their most important findings were that the public holds moderately favourable attitudes toward mental health professionals, and that the stigma of mental illness is general "There is a strong 'negative halo' associated with the mentally ill". They also considered that the public was unrelenting, in viewing the mentally as being all things 'bad'. Some of the bad attitudes the people have toward the mentally ill were partially supported by the facts - for example, the mentally ill sometimes were unpredictable and dangerous. However, the average man generalises to the point of considering the mentally ill as "dirty, unintelligent, insincere, and worthless". Nunnally considered that demographic characteristics have little effects on public attitudes. More positive perceptions of mental illness were described by Elinson et al (1967) who explored public conceptions of mental illness. The majority of the respondents expressed the belief that mental illness is similar to other illnesses, that there were different types of mental illness, and that it should be included in regular health insurance coverage. However, there was confusion about the various professional roles. People felt helpless towards mental illness in comparison with cancer and heart diseases. Half of the sample considered mental illness to be the most serious problem in the country.

In Britain, Maclean (1969) used structured interviews with 500 individuals picked from the electoral rolls in Edinburgh. The results showed that the public was familiar with mental illness and considered it less serious than malignant diseases. Education and personal contact with mental illness showed no effect on the perception of mentally ill people as violent and potentially unpredictable. However, she indicated that 1/3 of the respondents considered the mentally ill are dangerous, Further, 40% felt apprehensive that mental illness might be contagious, while personal experience of mental illness did not reduce the perceived danger.

While studies that identified negative public attitudes were: Star (1952) studied community attitudes to mental illness on a national level in America (1950). She presented six short case histories to a random sample of the population and questioned them about them. The result showed that aggressive paranoid descriptions were consistently recognised by the public as mental illness. She concluded that mental illness was seen by the public as a threatening and fearful thing and the mentally ill person is somebody who has lost his human qualities of rationality and free will. She also added that 'mental illness' is something that people want to keep as far from themselves as possible.

Phillips (1967) studied the effects of individual attitudes on identifying mental illness. He showed that increased public ability to identify mental illness would result in an increase in the rejection of the mentally ill. Similarly, Elinson (1967) indicated that the public differentiated between the terms mental and emotional illness. The person

with mental illness was likely to be perceived as dirty, unintelligent, insincere and worthless.

In a study in New Zealand, Green et al (1987) found that the community had not changed its negative attitudes toward the mentally ill over 20 years and did not want to take any role in patients' care in the community. They concluded that a change in public attitude needed to occur before the political and professional trend toward deinstitutionalization of the mentally ill and implementation of community care was realised.

These empirical investigations suggested that the main reason for negative public opinions is that the public lacks accurate knowledge about mental disorders, and consequently distort or exaggerate the amount and type of disturbance e.g. Cumming and Cumming, 1957; Star, 1952; Nunnally, 1961. On the one hand, some researchers investigated the notion that former psychiatric patients may be rejected because they continue to behave in a bizarre manner or fail to fulfil their social role requirements due to the debilitating effects of their illness (Gove and Fain, 1973; Lehmann et al, 1976). On the other hand, a number of authors (Cumming and Cumming, 1965; Phillip, 1963; 1966; Scheff, 1966) considered that the label and stigma of mental illness result in increased rejection by the public, and intensify the patient's symptoms and decrease his ability to lead a normal life.

1.5.2 Studies of Attitudes Toward Mental Illness of specific Groups:

In this section will be considered studies concerning groups that directly affect patients' adjustment in the community, such as patients' relatives and professionals.

For example, Mains et al (1965) studied the conceptions of mental illness held by a group of psychiatrists and a random sample of the general pubic. They found that both the public and the psychiatrists had similar views in that they did not consider troublesome behaviour as being indicative of mental illness. They also noticed that manic behaviour was not considered as an indicator of severe mental illness.

In addition, Walkey et al (1981) carried out a comparative study to identify attitudes of university students to mental health. They replicated the earlier studies carried out by Olmstead and Ordway (1963) and Olmstead and Durham (1976), their data being consistent with the earlier results. They concluded that there was a need for mental health professionals to develop positive attitudes to community care before considering alternatives to institutional care. Community concern and competence cannot be taken for granted. Goldstein and Blackman (1975) studied American university students' generalisation about the following concepts: Ideal person, Negroes, Alcoholic, Americans, Mentally ill, Mentally Retarded, Physically Disabled, Criminals, Yourself, and Drug Addicts. The students rated the concepts on 10 scales. The results showed that the concepts: Drug Addicts, Criminals, and Alcoholics were evaluated lower than Ideal person, Yourself and Physically Disabled. While Americans, Mentally Retarded,

Negroes, and Mentally Ill were in the middle range. Mentally Ill received a mixture of ratings: positive (imaginative, sensitive and meditative), neutral (quiet and impulsive) and negative (unreliable, grasping, quick-tempered, evasive and suspicious). Mentally ill was rated similarly as Mentally Handicapped on sensitive, impulsive and quiet scales.
Mentally Retarded was described as honest, kind, faithful, reserved, ignorant, naive, and

Mackey (1969) studied the personal concepts of the mentally ill among care-giving groups using the semantic differential scale technique. Forty-eight mental health professionals, 69 police officers, 59 councillors and 43 welfare workers take part. The data revealed that although the 4 groups reported a high level of contact with mentally ill people, there was a lack of consensus regarding definitions and descriptions of mental illness. Police officers and public welfare social workers tended to associate mental illness with psychotic-like and socially deviant behaviour. Counsellors and professional tended not to answer the questions, describing highly variable behaviour or giving individualistic accounts of mental health problems. Equally important is family shame and embarrassment for a mentally ill member, closely allied to a fear that their relatives come and live with them.

In addition, Ross (1962) pointed out that much of the family disturbance with mentally ill relatives stems from shame, misinformation and from confusion. However, regarding patients' relatives, Freeman and Simon (1963) investigated stigma from the view point of relatives of mental patients. The results showed that the relatives' feelings of shame with concomitant withdrawal were less than has widely been expected or assumed.

Conclusion: The public expressed ambivalence toward people with mental illness. Mental illness has certain characteristics which make the sufferers liable to general disapproval. Public perception of the mentally ill as consisting of only two types, "serious" and "nervous breakdown", unpredictable and aggressive, could be one to the major blocks of community care.

1.5.3 Factors Affecting Attitudes Toward Mental Illness:

Several factors were identified as being the possible causes of public perception of mental illness for example:

1. Concepts of mental illness: Several surveys have shown that members of the public often have no clear idea of what constitutes mental illness or what are the different types of mental illness. Sister Loretta Maria (1965) considered that the stigma related to physical conditions such as cancer, syphilis and tuberculosis was less serious than the stigma related to mental illness.
2. Prognosis of mental illness: If the illness is considered curable, patients are more likely to be accepted, whereas the "hopeless" cases are likely to be rejected.

3. Overt symptoms, patients who are aggressive or whose behaviour is a nuisance to the surrounding population are likely to arouse hostility, whereas quiet and withdrawn patients may be treated with pity or indifference. Unpredictable behaviour is likely to provoke fear and rejection. One way to uncover deeper attitudes toward mental illness is to examine the differences in public attitudes toward the normal and other disabilities in comparison to mentally ill person. For example, Furnham and Pendred (1983) studied public attitudes towards mentally and physically the people to identify the effect of visibility of the handicap. They found that the mentally handicapped were viewed more negatively than the physically handicapped.

4. Treatment: Psychotherapy tend to provoke mystical fascination around the mentally ill person. Physical treatments promote a hopeful attitude and acceptance. In countries where mental disorders are covered by medical insurance there is less hostility toward psychiatric patients than where psychiatric treatment is a burden on the families. However, Schwartz et al (1974) found that the treatment given to former mental patients was less important in determining their degree of acceptance or rejection within a community, than was former psychiatric patients' current level of impairment.

5. Beliefs about the causes of mental illness: the belief that mental illness is due to heredity, leads to the assumption that it has a poor prognosis. If mental illness is believed to be due to somatic causes, this lead to favourable attitudes, partly because of an increased hope in the curability of the illness and partly because the sufferer is not responsible for the illness. Those whose mental illness is supposed to be due to trauma, fatigue "nerves" are also better tolerated (WHO,1959).

6. Normality and abnormality: This concept differs according to the culture, community and time. Some investigations were carried out to identify whether or not attitudes differ according to the nature of the disability.

7. Community Institutions: Religions that teach respect for the individual, laws that protect the individual patient interest and his property, and education which involves mental health are more likely to positively influence attitudes towards mental illness.

8. Type of the society: In the rural society mental illness is relatively more accepted than in an industrialised society. Chan et al (1988) examined 338 Chinese secondary school students' attitudes toward physically disabled, emotionally disturbed, and mentally retarded people using the American scale of Attitudes toward Disabled Persons (SADP). The results showed that the physically handicapped person was viewed more positively than emotionally disturbed and mentally handicapped individuals. The researchers indicated that the Chinese students did not differentiate between the mentally disturbed and mentally retarded unlike the western studies conducted by Rubin and Roessler (1978). Type of neighbourhood, Segal and Moyles (1980) demonstrated conservative middle class communities were most likely to exhibit extreme negative reactions toward former psychiatric patients. Liberal, non traditional neighbourhoods

was accepting community. Liberal, non-traditional and conservative working class neighbourhoods could facilitate the social reintegration of sheltered - care residence.

9. The Neurotic conditions are relatively familiar and ordinary people find them easy to identify with. Whereas attitudes to psychoses are less favourable because schizophrenic patients are segregated from the public and thus unfamiliar. Nevertheless, attitudes toward schizophrenic patients tend to be generalised to include all types of mental illness, including mental handicap. For example, Penayo et al (1988) studied Nicaraguan attitudes to mental illness following the WHO guideline in an effort to develop mental health services with popular involvement. The researchers conducted structured interviews using 8 vignettes (describing epilepsy, acute psychotic episode, mental retardation, hypomania, severe psychotic depression, chronic schizophrenia, depressive neurosis and alcoholism) constructed by the WHO and adapted to the Nicaraguan culture. Concerning the severity of cases, schizophrenia was considered the most severe and depressive neurosis was the least severe disorder. Alcoholism was considered the most frequent and disturbing disorder.

10. Level of education: Attitudes depend on the level of education and work expectation. That is to say, societies with higher levels of education and more demanding jobs are more likely to reject the mentally handicapped. The effect of education on attitudes was studied by Lemkau and Crocetti (1962) in their Baltimore study. In addition to age, and high income, education showed effects on attitudes, however, a high proportion of the least educated group were able to identify mental illness. Similarly, Halport (1969) found the better educated, younger, higher status groups expressed themselves more on the subject. However, Blizard (1970) showed that education had no effect on attitudes, and age had a negative impact only for those over 40 years old, while previous contacts with mental illness significantly related to attitudes.

11. Proximity to mental health facility: Dear et al (1977) used SD and multidimensional scaling to measure the external effects of public programmes. They found that the main reasons for public opposition were invasion of privacy, fear for personal safety. Wolpert et al (1975) public opposition stem from tangible and intangible indirect effects. Tangible effects such as property value decline, increased traffic in the vicinity of the facilities. The intangible effect such as fear for personal security and dislike of loitering clients. Attitudes to social distance attitudes were also studied. It was found that avoidance provides a most frequent and effective way of preventing anxiety towards mental illness. Consequently, this avoidance or social proximity could affect patients and professional efforts in resettling them in the community. While Crocetti and Lemkau (1962) and Taylor et al (1979) and Smith (1980) considered that attitudes toward mental illness correlate positively with the presence of mental health facilities in the area and even we could determine attitudes toward mental illness beforehand. They added that there is positive correlation between public recognition of mental illness and

acceptance of mental illness and closer social proximity with mentally ill people. Rabkin el al (1984) concluded that community psychiatric facilities do not necessarily constitute a personal or community burden. Interestingly, Furnham and Rees (1988) postulated that an increase in the numbers of mentally ill people in the community had no significant negative effects on public beliefs and attitudes toward mental illness. They added that viewing schizophrenia as backward (low intelligence - lack of attention) is significantly related to stigmatisation. They also found that the implicit beliefs about schizophrenia were unrelated to the demographic variables of the respondents.

12. Contact with mental illness: While Dohrenwend et al (1962) showed that contact with mental illness has no effects on attitudes toward mental illness; Link and Cullen (1981) indicated the opposite.

13. Age: Young age was found to correlate positively with attitudes.

14. Personality factors: Those whose personality make up tends to discriminate other human groups because they belong to a different sex, race, religion, nation, tend also to show rejection toward mentally ill people. Moreover, Rosenberg and Attinson (1977) used both anecdotal and experimental data on attitudes towards mental illness, they found that working class people were likely to be authoritarian, less accepting of and more exclusionary toward those diagnosed as psychologically sick", less amenable to psychotherapeutic intervention than middle class group.

15. Socio-economic level: Large area of studies in attitudes towards mentally ill have revealed significant correlation between selected socio-economic variable and rejections and misunderstanding of the mental illness. Freeman and Simmons (1963); Gurin et al (1960) reported differences in social class regarding definition of mental health problems and their treatment. While, Hollingshead and Redligh (1958) pointed out that abnormal behaviour is more tolerated in lower class than upper class strata of society even though the behaviour may be disapproved of according to the class norm. However, Gove and Howell (1974) considered that people from lower socio-economic groups have more negative attitudes toward mental illness and treatment, and limited knowledge of such illness. People at all socioeconomic levels are more enlightened than 20 years ago. In contrast, Hall (1980) demonstrated that lower social class were less sympathetic to mentally ill people than higher class. While, Dohrenwend and Chin-Shong (1967) found that the lower and upper status groups define deviant behaviour differently. The upper status groups showed greater tolerance to deviant behaviour than did the lower status groups.

16. Public education about mental illness: Cheung (1990) examined a community campaign against a half-way house established in Shatin District in Hong Kong. He found that lack of public preparation has led to fear of mentally ill residents and problems in community relationships. He suggested early community education, involvement of community leaders in the planning, application of knowledge and skills of

social psychology in dealing with public panic and co-operation with the mass media to reach the public. In addition a change in attitudes and procedures employed by the staff were basic requirements for public preparation. The reasons for their objection were fear of physical violence deviancy, inappropriate placement and abusing their children.

It can be concluded that There are controversy regarding the relationships between factors that might affect public attitudes toward mental illness such and proximity to mental health facilities, contact with mental illness and social class. However, one could identify measures that might bring about positive changes in public attitudes such as:

Information about mental health, facilities and treatment may increase people trust. Acceptance of mental illnesses people not necessary encompasses an active and personal involvement of community members with former psychiatric patients but accepting their rights to live normal in the community. Mental health professionals' attitudes is crucial in implementing policies regarding mental health.

1.6 Critique of the Literature Review

The literature search on public attitudes produced studies since 1952. However, most of the listed studies are very narrow in scope. Even though some researchers indicated the urgent need to study public attitudes and its effects on patients readjustment in the community (Pryer et al, 1969; Hazelton et al, 1975; Miller, 1979; Dear and Taylor, 1982; and Wahl and Lefkowits, 1989), a few studies investigated the public reactions towards deinstitutionalization. Here also little research has been done to investigate if community care fosters greater acceptance of the mentally ill or not (Cumming and Cumming, 1957 Taylor et al, 1979 ; Segal and Mayles, 1980 and Cheung, 1990).

One of the pressing question in the field of public attitudes is the relationship between verbal attitudes and subjects' actual behaviour. Few experimental studies of behaviour toward mental patients have been adequately realistic. Only Holzberg & Gewirtz (1963) and Link and Cullen (1983) have done experiments which are reasonably realistic. Psychiatric patients in these studies seemed to evoke negative experiences more often than control groups.

In looking at attitudes towards mental patients, the most often studied variables are age education and proximity, but the level of validity and reliability in these studies is low. Reliability could be increased by the use of structured interviewing and common training. In general, studies that used open-ended interviews showed that public attitudes were generally positive (Crocetti et al, 1971), whereas those using vignettes, self-administered questionnaires, or closed rating scales produced more negative attitudes, such as the studies by Gove & Fain, (1973) and Wakely et al (1981). The inconsistency in the results of previous studies could be due to methodological factors. For example, Cumming and Cumming (1957) conducted two types of survey. One employed an

interview method using Star's vignettes in order to discover what behaviour was considered by the study sample as mental illness; the second used a self-administered questionnaire to determine social distance toward former psychiatric patients. Subsequent studies have examined attitudes using the same techniques or closed rating scales (Phillips, 1966; Dohrenwend & Ching-Shong, 1967; Phillips, 1967; Maclean, 1969; Blizard, 1970; and D'Arcy and Brockman; 1976). Other researchers have used open-ended interviews (Lemkau and Crocetti, 1962; Myer, 1964; Edgerton & Bentez, 1969; Crocetti et al, 1971; and Sissi et al, 1973).

Apart from the different methods used to assess attitudes the political climate and concepts of mental illness vary over time.

The most widely used scales Openion about Mental Illness (OMI) and Semantic differential (SD) were constructed with a specific group of respondents in mind, which limits their general use.

The advantages of self-administered questionnaires and closed rating scales are : ease of coding and analysis of data, as well as elimination of interviewer bias. However, these advantages are balanced by their disadvantages: lack of opportunities for respondents to elaborate on their answers, and built-in preconceptions about the important areas to investigate. Therefore, there is a good case for using a combination of closed and open-ended questions in an interview.

1.7 METHODOLOGY OF PUBLIC STUDY

This research is an enquiry into the public's perception of former psychiatric patients moving into their neighbourhood. The chief concern is with the local residents' common sense ideas and theories about mental illness. It is based on the assumption that local residents' attitudes toward the mentally ill stem from their preconceived ideas about mental illness rather than patients' behaviour. However, patients' behaviour could affect public attitudes either in a positive or negative way.

Furthermore, staff attitudes toward community care, their competence and approach to integration of psychiatric patients into a neighbourhood could affect public attitudes toward former psychiatric patients.

1.7.1 Design of the study

This study employed an experimental design. That is to say, two groups of local residents were identified: a study group and a control group. The study group consisted of 68 of the immediate neighbours of a group of patients moved from Friern and Claybury Hospitals. The control group comprised 60 of the residents of a road parallel to that of the study group, to minimise the likelihood of contact with the patients in the study area. The local residents identified were interviewed before the patients moved into the community and six months afterwards. Similarly, the staff employed to look after these patients were interviewed as soon as they were appointed, and six months after working in the community. Regarding the patients, they were interviewed while they were in hospital as soon as they had been identified by the staff, and six months after living in the community.

The design of the study included a control group in order to test the effect of independent variables. Investigating the attitudes of the control group would help to establish whether any change was the result of the presence of former psychiatric patients in the local community. If the control group showed an equivalent amount of change, it would be necessary to conclude that the change was not due to the independent variable, but rather that some other influence was affecting both groups.

The data set also fits into a longitudinal design study, since the variables utilized in this study were reassessed after six months to identify any changes in local residents', patients' and staff attitudes towards community care.

The variables of the study:

a. Independent variables are:

1. Characteristics of patients, staff and local residents.
2. Time, six months period between first and second interviews.
3. Preparation procedures for patients, staff and local residents.
4. Public perceptions of mentally ill people.

b. Dependent variables are:

1. Changes in local residents' attitudes towards former psychiatric patients moved into their neighbourhood.
2. Problems identified by staff during working in the community for six months.
3. Changes in patients' behaviour after living in the community for six months.

1.7.2 Objectives of the study:

The research project intends to identify:-

1. Local residents' perceptions of mental illness.
2. Local residents' reactions towards former psychiatric patients moved to live in their neighbourhood.
3. Effects of local residents' characteristics on their attitudes towards former psychiatric patients moved to live in their neighbourhood.
4. Local residents' opinions about community care.
5. Local residents' needs before former psychiatric patients move to live in the neighbourhood.

1.7.3 Null hypotheses:

The results of the study will show that:-

1. Local residents have negative attitudes towards people with mental illness.
2. There is no significant difference between the study and the control groups before and after patients moved into the study group area regarding:
sociodemographic characteristics of the respondents, their perceptions of some chronic conditions, their knowledge about mental illness and their opinions about psychiatric hospitals and mental health education.

1.7.4 Subjects of the public study

Sixty-eight residents in the study group and 60 in the control group on the first occasion. On the second occasion 47 in the study group and 41 in the control group.

1.7.5 Tools of the study

Semi-structured interviews conducted with the local residents before patients moved into their area and six months later. The objective of the interviews was to identify public attitudes towards mental illness and mentally ill people moved into their neighbourhood.

1.7.6 Description of tools of the study

Public perception of mentally ill semi-structured interview schedule. The questionnaire, which was developed by the researcher consists of four sections (Appendix 1):

1. Demographic data: respondents age, sex, household structure, education, employment and length of stay in the area. Social items including: social activities and relationships with neighbours.

Local residents were asked about their relationships with their neighbours. This question was asked twice, first about their present neighbours and then if any neighbours had been in a psychiatric hospital. The object of repeating this question was: first, to create a comparison between the local residents' present relationships with their neighbours and with former psychiatric patients in the neighbourhood. Secondly, to avoid biasing interpretation of the local residents' replies regarding their relationships with a former psychiatric patient who may be a neighbour, for example, if they have little interaction with their present neighbours, then poor interaction would not relate specifically to a former psychiatric patient who is a neighbour. Thirdly, to predict the type of neighbourhood the former patients are moving to. Fourthly to identify the effect of the neighbourhood on patients' adjustment in the community.

2. Perception of mental illness: items describing public perception of various chronic conditions, namely a person with mental illness, a person with epilepsy, a person with mental handicap and a person with diabetes. Causes and prognosis of these condition. Opinions about relationships with a neighbour who is a former psychiatric patient. This question was asked in order to compare it with the local residents' normal relationships with their neighbours. Other questions that could identify local residents' attitudes such as renting accommodation or socialising with former psychiatric patient, donating money to a charitable organisations for the mentally ill, and finally whether or not they would talk about a relative who is mentally ill to friends. The object of these questions is to predict the possibility of integrating former psychiatric patients into their neighbourhood.

3. Opinions about hospital care: This section was designed to elicit residents' views concerning hospital care. It was expected that viewing psychiatric hospital treatment as the only form of psychiatric treatment could produce resistance to hospital closure and community care.

4. Reactions to patients' transition into the community: This section dealt with local residents' views of former psychiatric patients' ability to adjust to the community. It also dealt with their contribution to helping the former psychiatric patient

to settle in the community as well as their opinion about opening mental health facilities in their area. Other items included were the local residents' needs for learning about mental illness.

The quantitative part of the public interviews will be presented in greater detail in section two of the methodology.

1.7.7 The pilot studies

Purposes of the pilot studies were to:

1. Test and refine the tools of the actual study to ensure that the questions of the semi-structured interview schedules were clear, simple and non-ambiguous.
2. Determine the organisational and administrative procedures needed for the actual research work.
3. Find out the time required for each interview.

Procedures of the pilot study:

Public interviews: an area outside the catchment area of both Friern and Claybury hospitals was chosen. The interview was administered by two interviewers to achieve the purpose of the pilot study.

In the course of the pilot study 14 members of the public were interviewed their homes and the necessary changes made to the schedule.

Results of the pilot study:

1. Some questions were omitted as they proved to be duplicated or were answered spontaneously in the course of conversation, by members of the public or staff. Other questions were added as it was considered they were important, e.g. it was noticed that the interviewees differentiated between types of treatment they had chosen for themselves and their relatives so two questions were added to clarify the distinction.

Similarly the questions to describe mentally handicapped people and nervous breakdown were added as the members of the public tended to confuse them with mentally ill people.

2. Reconstruction and re-phrasing of some questions was necessary as they were difficult to understand e.g when local residents were asked whether or not they would donate money to some charitable organisation, some members of the public thought that the researcher was asking them to contribute some money. Therefore the question was reconstructed and a statement that we are not asking for money was added.

3. The technique of establishing contact with local residents, patients and staff members, gaining their co-operation, and preparing them for the interview was developed to obtain the best results without interfering with normal activities.

4. The researcher became familiar with the questions and practised the appropriate technique to reduce the interviewee's anxiety.

5. The approximate time required for each interview was established, which helped in planning the research project.

1.7.8 Procedures of the study

In this part the procedures adopted to conduct interviews with each of the patients, staff and local residents will be dealt with separately.

1.7.8.1 Negotiation of access

At the beginning of the research study attempts were made to obtain consent from the appropriate ethical committee as well as planning team approval for the study. Despite consent being given by each ethical committee approached, considerable resistance was met particularly from administrators (non-qualified in the mental health field) and the planning team in two of the three districts. Resistance to the study appeared to be based on the following:

1. Negative attitudes toward consulting local residents' opinions regarding moving psychiatric patients into their neighbourhood arisen from the notion of "normalisation". According to this ideology psychiatric patients were entitled to move into a house without their neighbours being informed.

2. Anxieties of the planning team about stirring up local residents' objections and worries about the local mental health facilities opened in their area, which would lead to opposition to the closure plan. However, the researcher managed to obtain approval of the third district Haringey Ethical Committee and the Social Services department for the research project.

The researcher attended most of The Task Force Team meetings with The Grange staff until negotiation broke down regarding identification of suitable patients for the scheme.

Access to local residents began before the first interviews. A letter was sent to the local residents living within a hundred yards from The Grange one week before the actual interviews, by extracting the local residents names from the electoral roll (Appendix 2). At the end of each interview interviewees were asked whether or not they would be interested in a follow-up interview. Local residents showed great interest in participating in the study. One week after each interview a letter was sent to the local residents who participated in the interviews thanking them for their time and contribution to the research project.

Before the second interviews, another letter was sent just one week before the actual interviews reminding them that the second interview was due (Appendix 2).

Initially it was planned to interview the head of each household. However, due to difficulty in contacting this person each time, it was decided to concentrate instead on finding a family member who would be interested in participating in the study. Despite this change of plan, the letter was sent to the name of the person who was assumed to be the head of the household. On arriving at the doorstep, I introduced myself and referred to the letter. Local residents showed various reactions: some showed interest and welcomed the interviewer, others were ambiguous about the interview and needed some encouragement to participate. Some other residents showed suspicion, expressed in the form of further inquiries or a request to be accompanied by other neighbours or household members.

Others expressed fear of strangers by not opening their doors, talking behind the closed door, and indicating their wish not to take part in the interview. One of the neighbours related that one week previous to the study interviews, two women posing as social workers went around the area and burgled some of the houses. In addition the local policemen said that they had advised the local residents, especially elderly people, not to open their doors to strangers. Only two interviewees were verbally aggressive, not toward the interviewer but toward Mrs. Thatcher and various other politicians, expressing their disgust about the decisions to privatise the health service and close state hospitals.

1.7.8.2 Interviews

Adequate motivation was considered essential to obtain the co-operation of respondents. Atkinson (1971) identified various factors that affect the respondent's motivation, such as the length of the interview, topic of interest or importance, and "intrinsic motivation" of the respondent. Efforts were made to maintain the respondents' motivation so that all questions were answered. It appeared that the content of these interviews represented subjects of interest to the local residents. In addition a friendly and sincere manner facilitated willingness to be interviewed and enabled the gathering of rich information. Other factors were: being relaxed and giving time for the respondents to answer the question, listening to and valuing the respondent's opinions.

The response rate for the initial interviews was 75%. Those who refused to participate in the study did so at the doorstep, apart from 5% who sent the letter back with a notice of rejection of the interview. Main reasons for refusing to answer the questions were:

1. Fear of aggression (elderly people said that they had instructions not to open the door to strangers). Number=35
2. Interviewees' inconvenience. Number=15

The researcher introduced herself as a member of a research team at the local hospital whose aim was to elicit opinions about closing the local psychiatric hospital and about mental health. It was emphasised that their opinion was important to identify and

that the interview would not take much of their time. The researcher was careful not to refer to The Grange.

Most of the interviews took place in the local residents' homes. The questions were administered in varying order as some interviewees led the discussion of a subject according to their own interest. For example, if an interviewee had been in a hospital recently they started their interaction by talking about their visit. This would prompt the interviewer to start by asking questions related to their opinions about psychiatric hospitals and so on.

Following an answer, the interviewer would probe with further questions in an attempt to elicit more information, getting respondents to expand on their answers, or to give reasons for their opinions on particular issues.

The main advantage of using a face-to-face interview over the self-report method is that one can obtain more information, of greater depth and higher reliability. One can ask more complicated questions and explore specific areas in greater detail. Direct contact with the interviewees has the advantage that the questions can be explained and clarified, and ambiguities in the wording of question resolved. Because the questions were presented in a face-to-face situation, the interviewer could use, interpersonal skills to encourage respondents to express their feelings.

Interviewees were encouraged to relate in their own terms, experiences attitudes that were relevant to the research problem. There was no restriction by a rigid questionnaire, not all questions were asked in exactly the same order, and the researcher was able to follow up interesting points. Some degree of structure was necessary to maintain consistency and to ensure that all questions were answered; while providing an atmosphere in which the informant felt free to elaborate their ideas.

Interviews took between 30 minutes and more than an hour, as some respondents offered a drink to the interviewer or talked about personal matters that were relevant to the subject of the interview. Some of the interview time was also occupied by respondent attending to small children, and answering the telephone or the door.

1.7.8.3 Reliability

Inter-rater reliability was established by having two interviewers complete the questionnaire. Each interview was conducted by only one of the interviewers while the other, the "reliability" interviewer, remained silent and merely rated the responses. The main interviewer took the responsibility of explaining the purpose of the interview. Following a number of interviews both interviewers checked that they understood and recorded responses consistently.

Analyses:

Data were analysed mainly by the chi-square test which was applied to the contingency tables. Yates correction was utilized for small frequencies. Chi-squares

were computed for the real numbers, although in some tables only percentages are presented.

There is an argument as to whether qualitative techniques are considered a sufficient basis for scientific enquiry. The qualitative approach was used here to supplement numerical data with the aim of discovering the meaning the public gave to their relationships to mental illness. During each interview with members of the public and staff the verbatim answers were written down. Then a preliminary analysis was conducted to identify the main issues. Common themes were drawn out and categorized under main headings and sub-headings. The number of categories was then reduced, Then, major themes were established. Lastly, the reliability of categorisation was checked by comparing independent sorting by the author and two psychology assistants. Disagreements were resolved by discussion leading to a consensus.

Difficulties encountered during the study:

1. Inaccuracy of the electoral roll register, as people's names were either inaccurate or not up-to-date.
2. Attitudes of the planning team towards studies dealing with public reaction to mental health facilities in their area.
3. Tracing members of the public who were interviewed on the first occasion.
4. Tracing patients who were chosen by the staff members for The Grange and following them up after their discharge. Inconsistency among the staff about patients were moving to The Grange or the patients changing their mind about going to The Grange made identification of subjects difficult.

1.8 RESULTS

In this section the results of the semi-structured interviews will be presented. The results of the interviews will be described in two parts; first the characteristics of the population under study and the local residents' perceptions of mental illness, and their attitudes towards community care.

Nearly half of the interviews in both groups on both occasions were conducted in the presence of other members of the family: on the first occasion 44% in the study group and 60% in the control group, and on the second occasion 51% in the study group and 53% in the control group. It was inconvenient to carry out the interviews in a separate place. Only the participant's views were recorded.

Five subjects in the study group and 4 in the control group had language difficulties. This problem was overcome by English translation from another family member.

1.8.1 Number of Subjects

A total of 128 subjects were interviewed from both areas. In the first interview, 68 subjects in the study group (Tottenham) and 60 subjects in the control group (Haringey) participated in the study.

In the second interview, 2/3 of the subjects interviewed on the first occasion participated in the second interview; 47 subjects in the study group and 41 subjects in the control group. The main reasons for losing 1/3 of the sample were:

1. Moved from their accommodation = 10.
2. Absence of the interviewee at all times of calling = 17.
3. Respondent's inconvenience = 12.
4. Only 3 refused to be interviewed, for unknown reasons.

1.8.2 Power Testing*

Various power testing equations were applied to some of the results to identify the size of population, case proportion and the significance level required for a similar study in order to identify significant changes in public attitude. The analysis showed that to attain a degree of precision that is appropriate to the research aims, using a significance level of 0.05, in order to reach power 0.8 the sample size showed be between 90-250 subjects with one control per case.

Given the small sample size of approximately 60 an increase or decrease in proportion of at least 20% would be required to show significant changes in the study group.

Presentation of the Results

The results of the semi-structured interviews on both occasions will be described under the following headings and sub-headings:-

1.8.3 Sociodemographic characteristics of the study and control groups.
1.8.4 Relationships between participants and non-participants.
1.8.5 Local residents' perceptions of mental illness.
1.8.6 Local residents' knowledge about mental illness.
1.8.7 Local residents' opinion about psychiatric hospitals.
1.8.8 Local residents' perceptions of community care.
1.8.9 Local residents' reactions towards integrating with former psychiatric patients.
1.8.10 Public interest in education about community care.
1.8.11 Overview of the results

* the power of a test is defined as the probability of rejecting Ho when it is false (Seigal, 1986).

1.8.3 Sociodemographic characteristics of the study and the control groups

Generally, the results of the study showed that both population groups were similar in their social and demographic background. There were no significant differences between the two groups except in their educational background. Specifically there were

no differences between the study and the control groups for sex, household composition and activities, position of the respondent in the family, contacts with mental illness, length of stay in the area, type of accommodation and relationships with the neighbours. This similarity in their characteristics was reflected in their attitudes towards former psychiatric patients moving into their neighbourhood.

1.8.3.1 Sex Composition

It was found that equal numbers of men and women in both areas participated in the study in the first and second interview. In the first interview, men constituted 53% of the study group and 47% of the control group. In the second interview, men comprised 49% of the study group and 53% of the control group.

1.8.3.2 Position of the Participants in the Family:

For both occasions and locations it was found that wives and single people tended to be more highly represented in comparison with other members of the family. No difference in proportions between the study and the control groups was found (See Table 1.1).

Table 1.1 Cross-tabulation of Position in the Family by Study and Control Groups (First Interview)

Position in	Study Group		Control Group		Total	
the family	No.	%	No.	%	No.	%
Wife	22	32.4	16	26.7	38	29.7
Husband	17	25.0	15	25.0	32	25.0
Cohabitant	5	7.4	4	6.7	9	7.0
Sibling	4	5.9	4	6.7	8	6.3
Single	20	29.4	21	35.0	41	32.0
Total	68		60		128	100.0

1.8.3.3 Marital Status:

It was found that married and never married people were more highly represented than formerly married people (separated, divorced and widowed). Again, no difference in proportion between the study and the control group was found (See Table 1.2).

Table 1.2 Cross-tabulation of Marital Status by Study and Control Group (First Interview)

Marital Status	Study Group		Control Group		Total	
	No.	%	No.	%	No.	%
Married/Cohab	36	52.9	29	48.3	65	50.8
Never married	18	26.6	18	30.0	36	28.1
Ever married	14	20.6	13	21.8	27	22.1
Total	68		60		128	100.0

1.8.3.4 Age:

In the first interview, in both groups, it was found that 27.9% in the study group and 30% in the control group were between the ages of 18 and 29; and the smallest age band in both groups was between the ages of 50-59 (Table 1.3). Similarly, in the second interview, subjects between the ages of 18 and 29 participated more frequently. No difference in proportion between the study and the control groups was found.

Table 1.3 Cross-tabulation of Age by the Study and Control Group (First Interview)

	Study Group		Control Group		Total	
Age	No.	%	No.	%	No.	%
18-29	19	27.9	18	30.0	37	28.9
30-39	11	16.2	12	20.0	23	18.0
40-49	17	25.0	9	15.0	26	20.3
50-59	11	16.2	4	6.7	15	11.7
60-60+	10	14.7	17	28.3	27	21.1
Total	68		60		128	100.0

1.8.3.5 Households:

In both groups on both occasions, subjects with children or living with another partner participated more frequently than single persons. No difference in proportion between the study and the control group was found (See Table 1.4).

Table 1.4 Cross-tabulation of Household by Study and Control Group (First Interview)

Household	Study Group		Control Group		Total	
	No.	%	No.	%	No.	%
Single person	19	27.9	17	28.3	36	28.1
Couple with children	18	26.5	23	38.3	41	32.0
Couple	18	26.5	11	18.3	29	22.7
Single parent	8	11.8	5	8.3	13	10.2
Others	5	7.4	4	6.7	9	7.0
Total	68		60		128	100.0

1.8.3.6 Occupation:

In both locations on both occasions the non-earning population (students, unemployed and retired people) constituted the majority of the participants in the study as shown in Table 1.5. No difference in proportion between the study and the control group was found.

Table 1.5 Cross-tabulation of Occupation by Study and Control Group

Occupation	Study Group		Control Group		Total	
	No.	%	No.	%	No.	%
Unwaged	30	44.1	27	45.0	57	44.5
Professional	8	11.8	5	8.3	13	10.2
Skilled	9	13.2	14	23.3	23	18.0
Less skilled	21	30.9	14	23.3	35	27.3
Total	68		60		128	100.0

1.8.3.7 Education:

In both interviews, it was found that the participants in the control group were significantly more likely to have recognised certificates than those in the study group.

Table 1.6 Cross-tabulation of Education by Study and Control Group First Interview

Education	Study Group		Control Group		Total	
	No.	%	No.	%	No.	%
With certificate	25	36.8	36	60.0	61	47.7
No certificate	43	63.2	24	40.0	67	52.3
Total	68		60		128	100.0

chi2=6.9 p=0.009

Table 1.7 Second Interview

Education	Study Group		Control Group		Total	
	No.	%	No.	%	No.	%
With certificate	18	38.3	25	61.0	43	48.9
No certificate	29	61.7	16	39.0	45	51.1
Total	47		41		88	

chi2=4.5 p=0.034

1.8.3.8 Period of Stay in the Area:

The great majority of the study group and the control group had lived in the area for more than one year at the time of the interview (84% of the study group and 92% of the control group).

1.8.3.9 Ownership:

In both areas it was found that the majority of the subjects rented council flats (57% of the study group and 62% of the control group). More subjects living in council flats also participated in the second interview than subjects in non-council flats. (Tables 1.8 and 1.9).

Table 1.8 Cross-tabulation of Ownership by Study and Control Group (First Interview)

Ownership	Study Group		Control Group		Total	
	No.	%	No.	%	No.	%
Council flat	39	57.4	37	61.7	76	59.4
Not council flat	29	42.7	23	38.3	52	40.6
Total	68		60		128	100.0

Table 1.9 **Second Interview**

Ownership	Study Group		Control Group		Total	
	No.	%	No.	%	No.	%
Council flat	27	57.5	24	58.5	51	58.0
Not council flat	20	42.6	17	41.5	37	42.1
Total	47		41		88	

1.8.3.10 Activities:

Less than half of the participants, 38.2% of the study group and 43.3% of the control group, participated in social activities in their area. Examples of these activities are: 5.9% of the study group and 11.7% of the control group participated in voluntary activities, mainly for elderly and mentally handicapped people; 17.6% of the study group and 8.3% of the control group attend their local church regularly. It was found that 13.2% of the study group and 18.3% of the control group joined sports clubs. 11.8% of the study group and 10% of the control group attend the local community centre. A similar percentage in both groups (4.4% of the study group and 5% of the control group) were members of the Residents' Association. Only 6.7% of the control group take part in political activities. Other activities mentioned by 53.2% of the study group and 56.1% of the control group are, for example, Rotary Club, collecting money for various charitable organisations.

1.8.3.11 Relationships with Neighbours:

For all but one of the questions, no significant difference was found between the groups in their relationships with their neighbours. The components of neighbour relationships were:

a. casual interaction with their neighbours, maintained by 85.2% of the study group and 93.3% of the control group.
b. exchanging little services (collecting parcels for them, looking after the flat in their absence) mentioned by 44.1% in the study group and 53.3% in the control group.
c. visiting neighbours occasionally reported by 36.8% of the study and 43.3% of the control group.
d. inviting their neighbours in, indicated by 38.3% of the study group and 36.6% of the control group.
e. considering their neighbours as friends. In the study group fewer people considered their neighbours as friends, (14.7%) than in the control group, (20.3%, $p<0.013$).

1.8.3.12 Contact with Mental Illness

A relatively high proportion of the participants were diagnosed as mentally ill at some stage of their lives. In the study group 19.1% and in the control group 11.7% indicated that they had experienced a mental condition during their life. They described their conditions as nervous breakdowns or depression. Having a relative who suffered with a mental condition was mentioned by 39.7% of the study group and 25% of the control group. Some had recovered and some were still receiving treatment. Half of the subjects (48.5% of the study and 50% of the control group) said they knew somebody who was mentally ill. No significant difference was found between the groups with respect to these factors.

On asking the respondents to describe their relative's conditions, 52.9% of the study group and 48.3% of the control group identified their relative's condition as mental illness. Only 17.6% of the study group and 25% of the control group described their relative's or acquaintance's conditions as nervous breakdowns.

Even though respondents described their relatives and acquaintances as suffering from psychotic symptoms, 23.5% of the study group and 16.7% of the control group could not identify the psychotic condition and described it as depression or nervous breakdown.

Positive attitudes towards relatives and others with mental illness were expressed by 26.5% of the study group and 25% of the control group. Neutral attitudes were expressed by 8.8% of the study group and 5% of the control group, while 32.4% of the study group and 33.3% of the control group expressed negative attitudes.

Regarding the local residents' contacts with psychiatric hospitals, 60.3% of the study group and 56.7% of the control group knew somebody with mental illness treated in a psychiatric hospital.

1.8.4 Relationship between participants and non participants in the second interviews

About one third of the respondents (32%) of subjects interviewed initially did not participate in the second interview. Analyses of the results of participants and non-participants in both the study and the control groups in the second interviews showed no significant differences, suggesting that there is no selection bias from refusals.

Sociodemographic Characteristics

1.8.4.1 Sex Composition

The sex ratio approached equality among both participants and non-participants as shown in Table 1.10.

Table 1.10 A) Sex Ratio of Participants and Non-Participants

Sex	Non-Participants		participants		Total	
	No.	%	No.	%	No.	%
Male	19	46.3	45	51.7	64	50.0
Female	22	53.7	42	48.3	64	50.0
Total	41		87		128	100.0

1.8.4.2 Position of the Participant in the Family

Table 1.11 shows that, as with the participants in the first and second interviews, single people, wives and husbands were over represented in the non-participants in the second interviews.

Table 1.11 Position of the Participants in the Family:

Position	Non-Participants		Participants		Total	
	No.	%	No.	%	No.	%
Wives	12	29.3	26	29.9	38	29.7
Husbands	10	24.4	22	25.3	32	25.0
Siblings	4	9.8	5	5.8	9	7.0
Cohabitant	1	2.4	7	8.1	8	6.3
Singles	14	34.2	27	31.0	41	32.0
Total	41		87		128	100.0

1.8.4.3 Activities of Participants and Non Participants:

Similarly there was no significant difference between the two groups regarding their activities. 45.9% of the participants in the second interview and 29.3% of non-participants undertook various activities.

1.8.4.4 Contact with Mental Illness:

Almost identical proportions of participants and non-participants had mentally ill relatives. 19.5% of non-participants and 13.9% of participants were mentally ill themselves, while 67.5% of non-participants knew somebody in a psychiatric hospital, compared with 54% of participants. (See Table 1.12).

Table 1.12 Mentally Ill Relatives

Mentally Ill Relatives	Non-Participants		Participants		Total	
	No.	%	No.	%	No.	%
No	28	68.3	121	69.5	149	69.3
Yes	13	31.7	53	30.5	66	30.7
Total	41		174		215	

1.8.4.5 Perception of Mental Illness:

Attitudes towards the prognosis of mental illness were very similar in participants and non-participants alike as shown in Table 1.13. Statistical analyses were carried out on all the variables. No significant differences were found between the participants and non-participants regarding their attitudes to patients moving into their neighbourhood.

Table 1.13 Prognosis of Mental Illness

Prognosis	Non-Participant		Participants		Total	
	No.	%	No.	%	No.	%
Can be cured	10	24.4	26	29.9	36	28.1
Depends on type/ cause of illness	11	26.8	28	32.2	39	30.5
Incurable	16	39.0	28	32.2	44	34.4
Don't know	4	9.8	5	5.8	9	7.0
Total	41		87		128	

1.8.5 Public perceptions of a mentally ill person

In both first and second interviews, in response to the question of how would they describe somebody with mental illness, a quarter of both the study group and the control group said that it is difficult to identify mentally ill people. The remaining three quarters of interviewees indicated that mentally ill people could be identified by the following behaviours, as shown in the histogram (figure 1.1).

1.8.5.1 Difficult Communication

This was the most frequently identified characteristic of the mentally ill by 41% of the study group and 38% of the control group in the first interview. In the second interview, however, difficult communication was slightly less frequently identified by 36% of the study group but by unchanged proportion (38%) of the control group.

PUBLIC PERCEPTION OF THE MENTALLY ILL

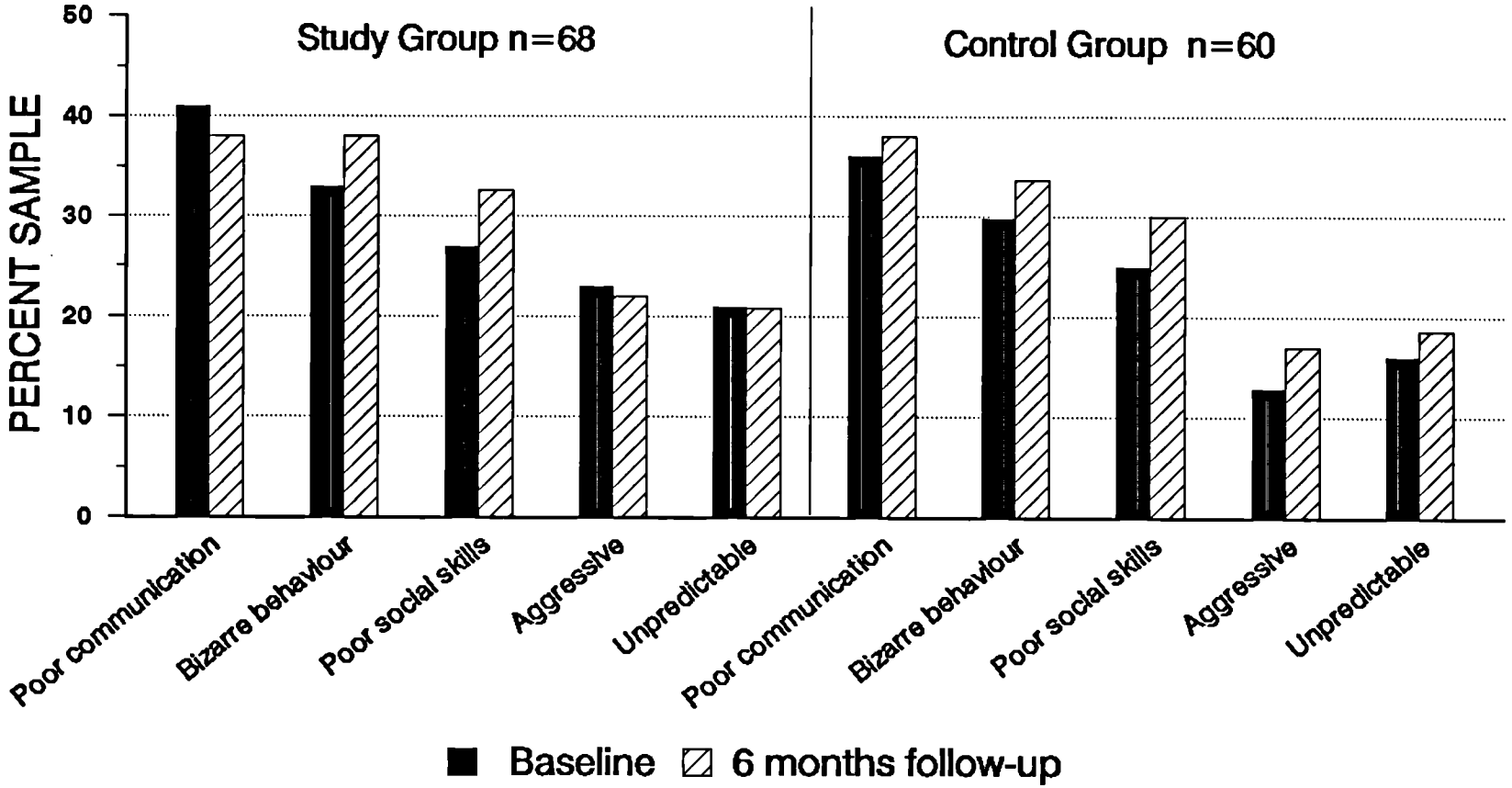


Figure 1.1

1.8.5.2 Bizarre Behaviour

In the first interview, bizarre behaviour was identified by 33% of the study group and 29.8% of the control group. In the second interview, bizarre behaviour was the most frequent characteristic, identified by 38% of the study group and 33.7% of the control group. Bizarre behaviour was described as odd, 'living in a world of their own', 'they are somehow different from anyone of us', go 'berserk', look 'vague', 'funny' and 'abnormal', walk 'like a zombie', seem 'strange' and 'muddled', they are 'difficult to understand'.

1.8.5.3 Lack of Social Skills

Mentally ill people were described as 'dirty', cannot look after themselves 'talk loudly', 'erratic', 'lack of inhibition' have bad habits, pick or scratch, 'spanner', 'swear and shout', 'don't talk properly', 'do not understand', 'lack of intelligence'. Lack of social skills was mentioned in the second interview more frequently (31.6% of the study group and 30% of the control group) than in the first interview (27% of the study group and 25% of the control group).

.8.5.4 Behaviour that is disturbing to the public

This was described by the local residents as 'unfriendly', keeping distance', prone to 'shoplifting', likely to 'walk naked', remaining 'very quiet', often 'chain smokers', 'asking for cigarettes' or 'begging'.

1.8.5.5 Abnormal Appearance

A quarter of the study group on both occasions and slightly less of the control group (16% on the first occasion and 22% on the second occasion) identified the mentally ill as 'have funny facial expressions', 'looks funny', 'their eyes roll backwards', 'wearing funny and unsuitable clothes'.

1.8.5.6 Distressed Behaviour

Twenty four percent of the study group and 12.9% of the control group on the second occasion described mentally ill people as 'nervy', 'jumpy' 'bite their nails' and 'shaky legs', they tend to 'lack self confidence'. Distressed behaviour was described on the first occasion less frequently (10.5% of the study group and 14% of the control group).

1.8.5.7 Aggressive behaviour

Mentally ill people were described as being 'violent', usually 'unpredictable', could be 'carrying knives', likely to be 'rapist' or 'hurt children', tend to be 'abusive'. Aggressive behaviour was mentioned more frequently in the first interview than in the second interview: 23% of the study group and 12.9% of the control group x2 significant at 5%.

1.8.5.8 Wandering about

A higher percentage of the study group (22.8%) than the control group 12.9%) in the first interview considered that mentally ill people wander about aimlessly in the streets. In the second interview however, both groups mentioned wandering behaviour equally frequently. 20.9% for the study group and 22% for the control group.

1.8.6 Local residents' knowledge about mental illness

1.8.6.1 Differentiation Between Various Chronic Conditions

Mental Handicap and Mental Illness

On both occasions a high proportion of local residents showed confusion between mental handicap and mental illness. (See Tables 1.14 and 1.15).

Table 1.14 Local Residents' Differentiation Between Mental Handicap and Mental Illness : (First Interview)

Mental Illness and	Study Group		Control Group		Total	
Mental Handicap	No.	%	No.	%	No.	%
No difference	28	41.2	24	40.0	52	40.6
A difference	40	58.8	36	60.0	76	59.4
Total	68		60		128	

Table 1.15 Local Residents' Differentiation Between Mental Handicap and Mental Illness: (Second Interview)

Mental Illness and	Study Group		Control Group		Total	
Mental Handicap	No.	%	No.	%	No.	%
No difference	14	29.8	17	41.5	31	35.2
A difference	33	70.2	24	58.5	57	64.8
Total	47		41		88	

Diabetes and Epilepsy

Local residents described diabetics and epileptics as normal and they said 'that one would not recognise, somebody with diabetes or epilepsy unless they had been told beforehand'.

Differentiation Between Nervous Breakdown and Mental Illness

Regarding nervous breakdown, local residents made a clear cut distinction between nervous breakdown and mental illness. In both interviews, 40% said that

nervous breakdown is 'different from mental illness'. Nervous breakdown 'could happen to anyone', it 'can be cured' and is 'not dangerous like mental illness. The majority of the respondents in both groups explained that the difference between nervous breakdown and mental illness is due to the cause of the condition. For example, nervous breakdown is believed to be caused by simple everyday problems such as family problems, stress, pressure at work, death or separation in the family. By contrast mental illness is seen to be caused by more serious factors such as heredity, organic conditions or long-standing psychologically stressful situations. In the public view these causes significantly differentiated between mental illness and nervous breakdown ($p<0.021$).

Another criterion for differentiation was that mental illness is seen as a more long-standing disease than nervous breakdown. Severity is an additional criterion, mental illness being considered a more serious condition than nervous breakdown.

1.8.6.2 Local Residents' Identification of Various Chronic Conditions

Epilepsy: nearly a quarter of both the study and the control groups have contacts with epileptic people. At both first and second interview both groups indicated that it is almost impossible to identify a person with epilepsy either by behaviour, mood, interaction or appearance.

Diabetes: as with epilepsy most of the respondents indicated that they would not be able to identify a diabetic person.

Mental Handicap: The study group showed marked differences from the control group in their contact with mentally handicapped people (22 subjects in the study group and only 6 subjects in the control group knew somebody who was mentally handicapped) ($p=0.003$), as shown in Tables 1.16 and 1.17.

Table 1.16 Identification of a Mentally Handicapped Person: (First Interview)

Identifying mental handicap	Study Group (n=68)		Control Group (n=60)		Total	
	No.	%	No.	%	No.	%
Behaviour	33	48.5	39	65.0	81	63.3
Mood	9	13.2	5	8.3	14	10.9
Appearance	42	61.8	29	48.3	62	48.4
Interaction	33	48.5	23	38.3	56	43.8

N.B. Columns do not add up to 68 and 60 because subjects can express more than one opinion.

Table 1.17 (Second Interview)

Identifying Total mental handicap	Study Group(n=47) No.	%	Control Group(n=41) No.	%	No.	%
Behaviour	24	51.1	29	70.7	57	44.5
Mood	3	6.4	2	4.9	5	3.9
Appearance	28	59.6	25	61.0	49	38.3
Interaction	26	55.3	20	48.8	46	35.9

N.B Columns do not add up to 47 and 41 because subjects can express more than one opinion.

The reason for this difference is the presence of a hostel for mentally handicapped people in the study area. Contacts with mentally handicapped people showed no effect on local residents' perceptions of them. Both groups considered appearance, behaviour and interaction as the most salient factors in identifying mentally handicapped people. Sex, education, occupation and household composition of respondent exerted no significant effect on opinions.

Mentally Ill

In both areas, the residents said that they would identify a former psychiatric person from his behaviour and interaction. In the first interview, the behaviour of a mentally ill person was significantly different ($p < 0.01$); in the second interview, mood was significantly different ($p<0.05$) between the study and control group. (See Tables 1.18 and 1.19).

Table 1.18 Identification of a Mentally Ill Person: (First Interview)

Identifying mentally ill	Study Group (n=68) No.	%	Control Group (n=60) No.	%	Total No.	%
Behaviour	48	70.6	43	71.7	91	71.1
Mood	22	32.4	13	21.7	35	27.3
Appearance	26	38.2	15	25.0	41	32.0
Interaction	43	63.2	37	61.7	80	62.5

N.B. Columns do not add up to 68 and 60 because subjects can express more than one opinion.

Table 1.19 (Second Interview)

Identifying mentally ill	Study Group (n=47)		Control Group (n=41)		Total	
	No.	%	No.	%	No.	%
Behaviour	36	76.6	33	80.5	69	78.4
Mood	6	12.8	13	31.7	19	21.6
Appearance	16	34.0	15	36.6	31	35.2
Interaction	27	57.5	27	65.9	54	61.4

N.B. Columns do not add up to 47 and 41 because subjects can express more than one opinion.

1.8.6.3 Perceptions of Causes of Mental Illness

As shown in Tables 1.20 and 1.21 social factors were considered the most important cause of mental illness in both interviews. The social factors identified by the local residents are: divorce, deaths in the family, family problems, unemployment, high work load, poor housing conditions, stresses and pressures of life. There was no significant difference between the study and control groups or between first and second interviews. Likewise, sex showed no effect on the respondents' answers.

Table 1.20 Local Residents' Perceptions of Causes of Mental Illness. (First Interview)

Causes of mental illness	Study Group (n=68)		Control Group (n=60)		Total	
	No.	%	No.	%	No.	%
Social factors	55	83.3	49	84.5	104	83.9
Heredity	26	39.2	20	34.5	46	35.9
Organic	11	16.7	5	8.6	16	12.9
Accidents	7	10.6	9	15.5	16	12.9
Others	18	27.3	16	27.3	34	27.4

N.B. Columns do not add up to 68 and 60 because subjects can express more than one opinion (Frequency Missing 4).

Table 1.21 (Second Interview)

Causes of mental illness	Study Group (n=47)		Control Group (n=41)		Total	
	No.	%	No.	%	No.	%
Social factors	33	73.3	28	77.8	61	75.3
Heredity	18	40.0	18	50.0	36	44.4
Organic	8	17.8	2	5.6	10	12.4
Accidents	4	8.9	3	8.3	7	8.6
Others	10	22.2	16	26.7	16	19.8

N.B. Columns do not add up to 47 and 41 because subjects can express more than one opinion (Frequency Missing 7).

1.8.6.4 Perceptions of Prognosis of Some Chronic Conditions

From Tables 1.22 and 1.23, there was a consistency between the study and the control group in perceiving the prognosis of the four chronic conditions. Twice the number of people saw mental handicap as incurable as mental illness. Mental illness was seen as more curable than any of the other conditions. Sex showed no effect on both the study and the control groups' perceptions of prognoses of the four chronic conditions in both first and second interviews. However, with regard to the perception of mental handicap as a controllable condition, 25% of the female respondents as opposed to 75% of the male population considered mental handicap to be a controllable condition.

Table 1.22 Perceptions of the Prognosis of Some Chronic Conditions (First Interview)

Curability of	Study Group		Control Group		Total	
	No.	%	No.	%	No.	%
Mental Illness	20	29.4	16	26.7	36	28.1
Mental Handicap	8	11.8	9	15.0	17	13.3
Epilepsy	12	17.7	4	6.7	16	12.5
Diabetes	7	10.3	6	10.0	13	10.2
Total	68		60		128	

Table 1.23 (Second Interview)

Curability of	Study Group		Control Group		Total	
	No.	%	No.	%	No.	%
Mental Illness	11	23.4	14	34.2	25	28.4
Mental Handicap	3	6.4	2	4.9	5	5.7
Epilepsy	4	8.5	5	12.2	9	10.2
Diabetes	8	17.0	9	22.0	17	19.3
Total	47		41		88	

Prognosis of Mental Illness

An equal number of local residents considered mental illness curable as the number who considered it incurable. Nearly half of the respondents considered that the prognosis of mental illness depends on the severity of the condition, and the cause of the condition in the first place e.g. if due to heredity, it will not be cured. No change in the opinions of both groups occurred regarding the prognosis of mental illness in the second interview.

1.8.7 Local residents' opinions about psychiatric hospitals

Nearly one third of both the study and the control groups knew of somebody in a psychiatric unit or had visited a psychiatric hospital (See Tables 1.24 and 1.25).

Table 1.24 Local Residents' Reactions To Psychiatric Hospital (First Interview)

Reactions to	Study group		Control group		Total	
Psych.hospitals	No.	%	No.	%	No.	%
Positive	24	36.4	21	36.7	45	35.7
Neutral	4	16.1	7	11.7	11	8.7
Negative	18	27.3	19	31.7	37	29.4
Don't know	20	30.3	13	21.7	33	26.2
Total	66		60		126	

Table 1.25 (Second Interview)

Reactions to Psych.hospitals	Study group No.	%	Control group No.	%	Total No.	%
Positive	20	42.6	15	36.6	35	39.8
Neutral	11	23.4	7	17.1	18	20.5
Negative	8	17.0	10	24.4	18	20.5
Don't know	8	17.0	10	24.4	18	20.5
Total	47		41		88	

In both interviews, local residents showed positive reactions towards psychiatric hospitals. When local residents were asked whether or not they would consider psychiatric hospital admission for a relative who is mentally ill, nearly half of them said they would admit their relative to a psychiatric hospital.

1.8.8 Reactions towards the decision to close psychiatric hospitals

An equal number of the local residents in both areas knew about the decision to close psychiatric hospitals. Half [55.9%] of the study group and [53.3%] of the control group knew about the decision through the media, either a local paper, national paper, T.V. or through talking to friends. Other sources of knowledge were work and from relatives working at the local hospitals. Older age groups were significantly more knowledgeable about the decision than the younger residents ($p<0.05$).

Table 1.26 Public Knowledge About the Decision to Close Psychiatric Hospital

Knowledge about the Decision	Study Group No.	%	Control Group No.	%	Total No.	%
First Interview	38	55.9	32	53.3	70	54.7
Second Interview	32	68.1	30	73.2	62	70.5

As shown in the Tables 1.27 and 1.28, in both interviews a predominant proportion of the local residents rejected the decision to close psychiatric hospitals.

Table 1.27 Reactions Toward the Decision to Close Psychiatric Hospitals (First interview)

Reactions	Study group		Control group		Total	
	No.	%	No.	%	No.	%
Positive	20	29.9	17	28.8	37	29.4
Neutral	14	20.6	16	26.7	30	23.4
Negative	33	48.5	26	43.3	59	46.8
Total	67		59		126	100

Table 1.28 (Second interview)

Reactions	Study group		Control group		Total	
	No.	%	No.	%	No	%
Positive	9	19.2	7	17.5	16	18.4
Neutral	12	25.5	10	25.0	22	25.3
Negative	26	55.3	23	57.5	49	56.3
Total	47		40		87	

1.8.8.1 Relationships Between Knowledge About the Decision of Hospital Closure and Accepting It

The results in Table 1.29 showed that the knowledge about the decision to close psychiatric hospitals in both groups has no significant effects on accepting it.

Table 1.29 Relationships Between Knowledge About The Decision of Hospital Closure and Accepting It

Knowledge about the decision	First Interview				Second Interview			
	Agree		Disagree		Agree		Disagree	
	No.	%	No.	%	No.	%	No.	%
Knew about the decision	30	58.8	35	50	24	80	34	66.7
Did not know	21	41.2	35	50	6	20	17	33.3
Total	51		70		30		51	

N.B. Columns do not add up to 68 and 60 because 7 subjects abstained from answering the question.

1.8.8.2 Alternatives to Psychiatric Hospitalisation

As shown in Table 1.30, between 1/3 and 1/2 of the population was aware of alternative facilities for psychiatric problems other than hospitalisation. For example, G.P., self-support group, own homes, spiritual help, family support, church, talking to a psychiatrist without drugs, counselling, somebody to come and help you at home, and crisis centres. Even though local residents mentioned hostels, half-way houses and group homes in their discussion they could not recognise them as alternatives to hospitalisation.

Table 1.30 Alternative To Psychiatric Hospitalisation

Interview	Study Group		Control group		Total	
Number	No.	%	No.	%	No.	%
First Interview	25	36.8	29	48.3	74	57.8
Second Interview	17	36.2	22	35.7	39	42.2

1.8.8.3 Admit A Relative to A Psychiatric Hospital

Whereas a high proportion of local residents chose treatment in a psychiatric hospitals for their relatives, when it came to themselves they preferred treatment in the community to going to a psychiatrist, and a general hospital than going a psychiatric hospital (See Tables 1.31 and 1.32).

Table 1.31 Admit a Relative to a Psychiatric Hospital

Number of	Study group		Control group		Total	
Interview	No.	%	No.	%	No.	%
First Interview	59	88.1	47	79.7	106	84.1
Second Interview	43	91.4	36	87.8	79	97.5

Table 1.32 Admit Self to a Psychiatric Hospital

Admission to	Study group		Control group		Total	
psych. hospital	No.	%	No.	%	No.	%
First Interview	13	19.1	16	26.6	29	22.7
Second Interview	9	19.2	5	12.2	14	18.9

Many local residents indicated that they would not go to a psychiatric hospital except under certain conditions. For example:-

1. Their doctor recommended it to them.
2. There is nobody to look after them at home.
3. Their condition is so bad that they might be a danger to others or to themselves.
4. They prefer to be in the company of others under these circumstances
5. They considered that psychiatric hospitals are more specialised in treating these conditions and that they have qualified staff and appropriate equipment.

1.8.9 Reactions towards community care

1.8.9.1 Local Residents' Opinions About Ability of Former Psychiatric Patients to Live Outside Psychiatric Hospitals

In both interviews, more than half of the respondents in both groups thought that former psychiatric patients could live in the community, outside the institutions. A quarter of both groups indicated that former psychiatric people could live outside hospitals with community support. Only less than a quarter said that ex-psychiatric patients cannot live normal lives outside psychiatric hospitals. (See Tables 1.33 and 1.34).

Table 1.33 Local Residents' Opinions About Types of Accommodation Suitable for Former Psychiatric Patients (First Interview)

Types of Accommodation	Study Group No.	%	Control Group No.	%	Total No.	%
Independent	20	29.4	14	23.3	34	26.6
Sheltered	36	52.9	30	50.0	66	51.6
Special Accommodation	12	17.7	16	26.7	28	21.9
Total	68		60		128	

Table 1.34 (Second interview)

Types of Accommodation	Study Group No.	%	Control Group No.	%	Total No.	%
Independent	14	29.8	12	29.3	26	29.5
Sheltered	24	51.1	19	46.3	43	48.9
Special Accommodation	9	19.1	10	24.4	19	21.6
Total	47		41		88	

As shown in Tables 1.33 and 1.34, half of the respondents considered that staff-supported sheltered accommodation is essential in order for ex-psychiatric patients to be able to live in the community. A quarter of the local residents indicated that ex-psychiatric patients are able to live independently in the community.

1.8.9.2 Reactions Towards Opening of Mental Health Facilities in the Neighbourhood

The study and control groups were asked whether or not they had heard about mental health facilities opening in their neighbourhood. In the first interview none in both groups knew about mental health facilities, except one person in the control group who is a nurse and applied for a job advertised for that facility. In the second interview, 63.8% of the study group [33 subjects out of 47] knew about the facility. Almost half of them, 17 subjects, indicated that they had talked to or seen the people there, for example visiting the facility when it first opened, seeing the residents coming in and out of the building, meeting them in the local shops or G.P. Clinic. The remaining subjects [30] (36%) could not identify the facility, but recognised the building as belonging to Haringey Council because they saw a van standing outside with Haringey symbol on it.

In the control group, apart from the nurse who knew about the Grange in the first interview no one had learned about the facility by the second interview.

Table 1.35 Reactions Toward Mental Health Facilities (Second Interview)

Reaction	Study group		Control Group		Total	
	No.	%	No.	%	No.	%
Positive	44	93.6	34	82.9	78	88.6
Negative	3	6.4	7	17.1	10	11.4
Total	47		41		88	

Table 1.36 Local Residents' Willingness to Help (Second Interview)

Reactions	Study Group		Control Group		Total	
	No.	%	No.	%	No.	%
Willing to help	34	72.3	26	43.3	60	68.2
Not willing to help	10	21.3	11	26.8	21	23.9
Conditional help	3	6.4	4	9.6	7	8.0
Total	47		41		88	

As shown in Tables 1.35 and 1.36 an overwhelming majority of the local residents showed positive attitudes towards opening of mental health facilities in their neighbourhood. They also showed interest in offering help to the mental health facility. They indicated that mental health is lacking facilities and that it is time for the government to open more facilities in the area. They also mentioned that they might use these facilities in the future. The study group indicated that the mental health facility caused no disturbances to the area and that the clients were accompanied by the staff members most of the time. They described the residents as 'very old and they would not cause harm to anybody'. However, they indicated that they, the residents, went to the local shops dressed in light clothes and slippers in the winter. They also expressed worries about their presence in the area as they considered the area is 'rough' and they might get mugged. Furthermore the road is very busy and they might get knocked over by the traffic.

1.8.10 Local residents' reaction towards integrating with former psychiatric patients

1.8.10.1 Donation to Charitable Organisations

From Tables 1.37 and 1.38, local residents showed more sympathy towards mentally handicapped than mentally ill people. In the first and second interviews nearly half of the local residents showed great interest to donate money for charitable organisations for mentally handicapped people, while only a quarter of the residents were likely to donate for mentally ill.

Table 1.37 Proportion of Subjects Who Would Give to Charity (by disablement) : (First interview)

Chronic condition	Study Group		Control Group		Total
	No.	%	No.	%	
Mental handicap	33	48.3	30	50.0	63
Mental illness	19	27.9	17	28.3	36

Table 1.38 Proportion of Subjects Who Would Give to Charity (by disablement) : (Second interview)

Chronic condition	Study Group		Control Group		Total
	No.	%	No.	%	
Mental handicap	22	46.8	19	46.3	41
Mental illness	10	21.3	7	17.1	17

Local residents explained the reasons for their sympathy towards mentally handicapped people as follows:

a. Personal contact: expressed as 'I have a relative who is mentally handicapped'.
b. Paternalistic attitude: described as 'Mentally handicapped they are very little children, born with it, they deserve the money'.
c. Severity of mental handicap: local residents said: 'They really need money, it is difficult for them to earn a living and they depend on society', and 'Mentally handicapped cannot help themselves, but mentally ill and others can, it is a most severe condition.'
d. Confusion between mental and physical handicap: 'Mentally handicapped need money to buy equipment as wheelchairs and things like that'.
e. Feeling pity for mentally handicapped people: this expressed as 'Mentally handicapped are friendly, look younger, I always feel they are pitied, always need help.'

1.8.10.2 Charitable Organisations for Diabetics or Epileptics:

Less than a fifth of the subjects said they would give to diabetic or epileptic charitable organisations.

1.8.10.3 Renting Accommodation to People with Various Chronic Conditions

Local residents showed a preference towards renting a room or a flat to people with a diabetic condition rather than other groups of people. Local residents said that they would not identify a diabetic person because 'they are more normal than the others', 'they are less trouble; while they said of mentally handicapped people 'they cannot live by themselves', 'they will always need help'. They referred to the mentally ill as 'unpredictable" and 'dangerous'. The remaining respondents refused to choose among them as shown in Tables 1.39 and 1.40.

Table 1.39 Renting Accommodation to People with Various Chronic Conditions: (First interview)

Renting	Study Group		Control Group		Total	
Accommodation	No.	%	No.	%	No.	%
To mentally ill person	8	11.8	5	8.3	13	10.2
To mentally handicapped	9	13.2	4	6.7	13	10.2
To diabetic person	41	60.3	34	56.7	75	58.6
To epileptic person	8	11.8	10	16.7	18	14.1
Refused to choose	2	3.4	7	11.7	9	7.0
Total	68		60		128	100.0

Table 1.40 (Second interview)

Renting Accommodation	Study Group No.	%	Control Group No.	%	Total No.	%
To mentally ill	4	8.5	6	14.6	10	11.4
To mentally handicapped	7	14.9	2	4.9	9	10.2
To diabetic person	21	44.7	23	56.1	44	50.0
To epileptic person	11	22.4	6	14.6	17	19.3
Refused to choose	4	8.5	4	9.8	8	9.0
Total	47		41		88	

1.8.10.4 Socialising With Former Psychiatric Patients

Even though more than three quarters of the local residents said that they would attend a club which former psychiatric patients are also attending, local residents showed only slight interest in socialising with former psychiatric patients. This has been expressed as 'I am not a sociable person', 'as long as it is a club for other people as well', 'not by my own, with company', 'depends on the percentage of mentally ill there'. Five residents in each group made it a condition that they would attend a club for ex-psychiatric patients only if they were going to do a specific job in the club to help the members (See Table 1.41).

Table 1.41 Public Reactions Towards Socialising With Mentally Ill People

Attending a club	Study group No.	%	Control group No.	%	Total No.	%
First Interview	51	75.0	51	85.0	102	58.6
Second Interview	39	83.0	33	80.5	72	41
Total	90		84		174	

1.8.10.5 Reactions Towards Working With Former Psychiatric Patients

There were minimal changes between the first and second interview in the local residents' interest in working with former psychiatric patients as shown in Table 1.42. In both groups, about half of the respondents laid down conditions for work, as for example, 'I work with him but would not wish to share a business with him' 'If the work does not involve sharp instruments it is okay', 'If he is receiving enough support or help from the hospital'.

On the other hand other residents expressed positive views such as, 'I will be sympathetic' 'I will help him'. The idea of working with former psychiatric patients was

expressed as 'everybody needs to earn a living', 'I will never stop anybody from earning his bread and butter'.

Table 1.42 Favourable Reactions Towards Working With Former Psychiatric Patients

Working with ex-patients	Study group No.	%	Control group No.	%	Total No.	%
First Interview	43	63.2	37	61.7	80	57.1
Second Interview	32	68.1	28	63.3	60	42.9

1.8.11 Public interest in education about mental illness

1.8.11.1 Local Residents' Opinion About Preparation Required Before Former Psychiatric Patients Move Into Their Neighbourhood

As in Table 1.43, the majority of the local residents showed interest in knowing if any other mental health facilities will be opened in their area. Both male and female respondents showed similar interest.

Various reasons were given for the need to know about the opening of mental health facilities in the future, for example 'to know what is happening in the area', one commented 'to know how far it is from my house', 'I might need to move further away'. 'To know how to treat them and give help, and avoid clashes with them.'

Table 1.43 Local Residents' Need to be Told about the Opening of Mental Health Facility in their Area

Needs to be Told in the Future	Study group No.	%	Control Group No.	%	Total No.	%
Yes	38	80.9	33	80.5	71	80.7
No	9	19.2	5	12.2	14	15.9
Others	0	0	3	7.3	3	3.4
Total	47		41		88	

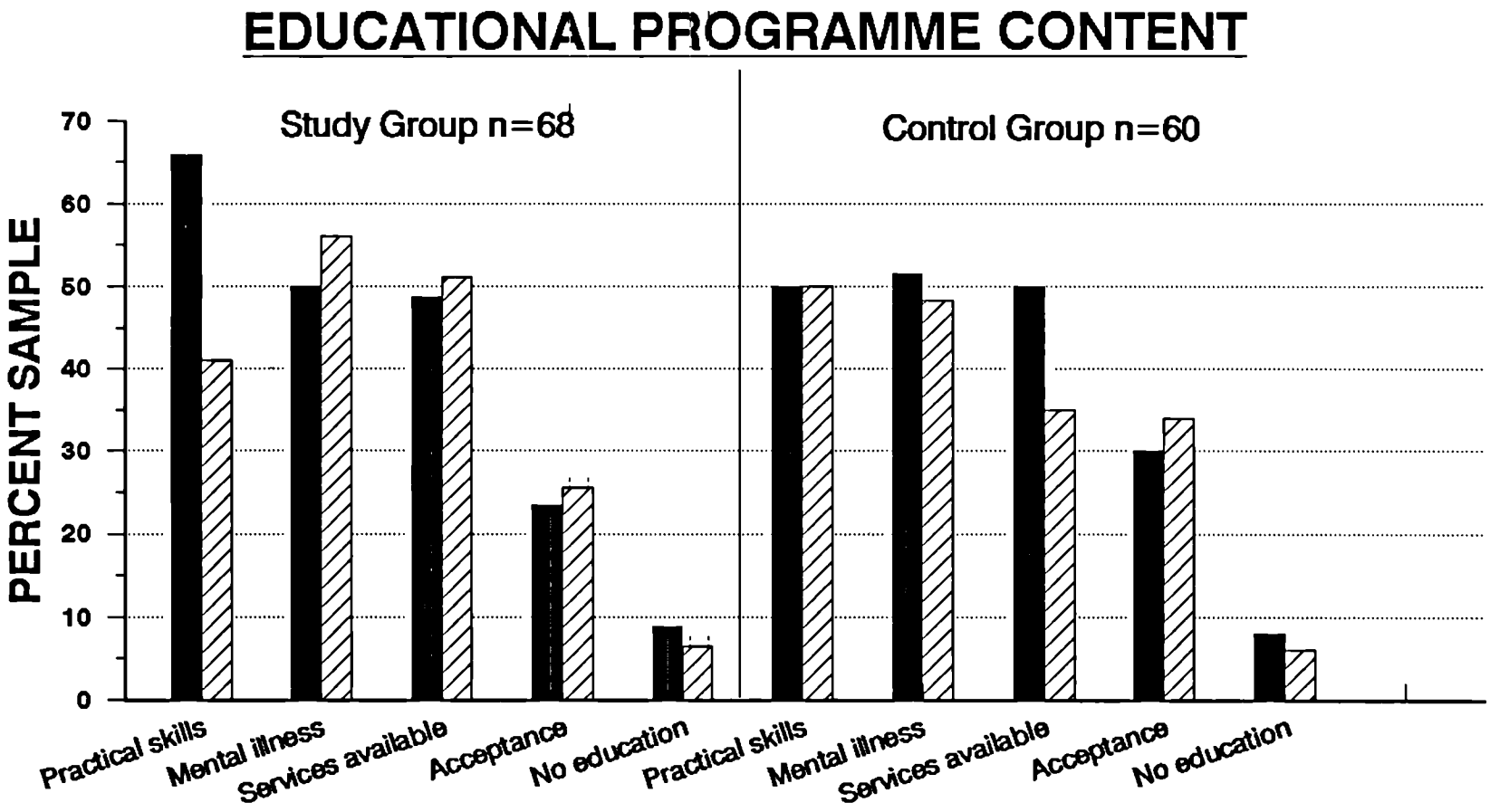

EDUCATIONAL PROGRAMME CONTENT
Study Group n=68
Control Group n=60
PERCENT SAMPLE
70
60
50
40
30
20
10
0
Practical skills
Mental illness
Services available
Acceptance
No education
Practical skills
Mental illness
Services available
Acceptance
No education
Baseline
6 months follow-up

Figure 1.2

1.8.11.2 Local Residents' Needs for Preparations

Table 1.44 shows that more than half of the respondents in both groups on both occasions indicated that it is important to prepare the local residents before opening mental health facilities in their neighbourhood.

Table 1.44 Local Residents Opinions About The Need For Preparation

Number of Interview	Study Group No.	%	Control Group No.	%	Total No.	%
First Interview	45	67.2	30	51.7	75	58.6
Second Interview	26	56.5	27	65.9	53	60.2

Figure 1.2 shows that in the first interview, more than half the respondents were interested in medical knowledge, while 15% were interested in psychological preparations. Nearly a quarter of the respondents wanted information about the background of the patients, for example, what is their condition, whether or not they are likely to be aggressive, causes of their condition, how to approach them. Some residents asked if they could have a report about any ex-psychiatric patient moving into their neighbourhood.

Age showed no significant association with local residents' opinions about their need for preparation. However, the younger age groups showed a tendency towards greater need for preparation. Likewise contacts with mental illness showed no significant influence on local residents' opinions about preparation. However, the less contacts some respondents had with mental illness the more likely they were to ask for knowledge about mental illness before ex-psychiatric patients were discharged. In terms of household composition, residents living with others showed more positive reactions towards preparation than single residents ($p<006$).

Sex: females in both areas showed significant difference in their need to learn about mental illness in general ($p<0.003$) and to learn about the services available ($p<0.041$).

1.8.11.3 Local Residents' Opinions About Mental Health Education

Local residents suggested that a programme of mental health for the general public should contain the following items (Figure 1.2):

1. Practical skills as for example, how to approach a mentally ill person and how to deal with certain behavioural problems.

2. Mental illness, as causes, types, prevalence and level of seriousness of mental illness.
3. Services available for treatment of mental illness.
4. Acceptance, educating the public about the importance of accepting mentally ill people.

On both occasions in both groups local residents showed a great need to know about mental illness. There was an obvious increase in the needs to know about hospitals and patients in the second interview in both groups. Sex showed no effect on the need for educating the public except regarding the need to learn about mental illness and the types of services available ($p<003$) and ($p<041$) respectively.

Likewise household composition showed no significant influence on the needs for education except on the respondents' needs to learn about mental illness.

1.8.11.4 Who Should Prepare Local Residents Before Patients' Discharge

More than half of the study (58%) and control groups (56%) on both occasions, suggested that the NHS (hospitals, doctors and nurses) should prepare local residents before ex-psychiatric patients move to their neighbourhood. Fourteen percent of the study group and 13% in the control group suggested social services, this was followed by the local council, mental health facilities that will open in the area and any charitable organisation for mental illness such as Mind. They also suggested that the presence of patients who are moving to their neighbourhood could be most useful as this would give them their first practical experience of mental illness.

1.8.11.5 Effects of Home Ownership on the Needs for Education

As shown in Table 1.45, while home owners were more interested in reassurance regarding mental illness e.g. the prevalence of mental illness, whether or not mental illness is dangerous, council tenants were interested in education about mental illness e.g. causes, treatment, and different types of illness.

Table 1.45 Effects Of Home Ownership On The Needs For Education (First Interview)

Items	Own their house		Council tenants		Total
	No.	%	No.	%	
Needs education about mental illness	15	35.6	38	69.1	55
Needs for reassurance	17	32.7	9	37.5	24

1.8.11.6 Modes of Education

Source of knowledge about Mental Illness

Both the study and the control groups indicated that they acquired their knowledge about mental illness through 5 sources:

1. Media: through T.V. and reading articles or books about mental illness: 42 in the study group and 34 in the control group.
2. Personal experience: either the respondent himself suffered from mental illness or they came into contact with relatives or acquaintances who were mentally ill; 35 on the study group and 29 in the control group.
3. Talking to other people: through casual conversation in public houses or in common places; 34 in the study group and 24 in the control group.
4. Seeing mentally ill people in the streets or the shops; 16 in the study group and 13 in the control group.
5. Work experience or attending in-service training courses; 3 nurses and home helps in each group.

Local Residents' Opinions About Modes of Education

In the first interview, the study group showed a predominant interest in learning about mental illness through door-to-door discussion. Their second choice was through news letters delivered through the letter box. The first choice for the control group was the media and their second choice was also the news letter and door-to-door discussion (See Table 1.46). In the second interview, both groups chose the media as the preferred way to learn about mental illness, then the newsletters and door-to-door discussion. Both groups explained that door-to-door discussion would help them to understand information about mental illness because it is a flexible method allowing them to ask questions. However, they indicated that it is time consuming, could be dangerous and that it involves inconvenience.

Table 1.46 Local Residents' Opinions About The Modes of Education

Modes of Education	Study Group				Control Group			
	1st int.		2nd int.		1st int.		2nd int.	
	No.	%	No.	%	No.	%	No.	%
Media	16	25	24	53.3	26	44.8	19	47.5
Door-to-door discussion	24	37.5	16	35.6	17	29.3	11	27.5
News letters	21	32.8	17	37.8	18	37.0	12	30.0
Public mtg.	13	20.3	3	6.7	3	5.2	5	12.5
Others	10	15.4	8	17.8	10	17.0	9	22.5

N.B. Columns do not add up to 68 and 60 because subjects can express more than one option.

As far as newsletters are concerned, respondents indicated that they can read them in their spare time and they are available at all times. However, they indicated that some people do not take notice of newsletters coming through the letter-box. Sometimes they are unclear, and also some people are illiterate. They suggested a telephone number at the end of the news letter that they can telephone for more information.

In the second interviews both groups showed a preference to learn through the media because it is cheaper than door-to-door discussion, it leaves an open option for who wants to learn and it can reach many people at the same time. It also involves visual images which might clarify the information. They gave as an example documentary programmes. They suggested other methods of learning about mental illness, for example, lessons in the classrooms for children, pamphlets at health centres, talks at churches or local psychiatric hospitals. Some local residents suggested a flag day for national education about mental illness. Minority groups such as Greeks and Indians suggested discussion in the social clubs for different minority groups in their own languages.

Local residents who considered that education about mental illness was not needed, explained that people would not give attention to the information unless mental illness concerned them in a personal way e.g. having a mentally ill relative. They also claimed that publicity about mentally ill people could increase public prejudice or rejection of mental illness. It also could lead to fear, and they gave examples like publicity about AIDS.

1.8.12 Overview of the results

Overall the results showed some positive changes in local residents' attitudes. However, these changes in attitude were mostly on the margin of significance or non significant between the study and control groups over time. For example a greater proportion of the study group made a distinction between nervous breakdown and mental illness on the basis of cause of condition ($p<0.021$). Similarly a greater proportion of the study group reported a difference in appearance of mentally ill people ($p<0.01$). In the second interview, patients' emotional reaction was as significant at 5%. Older people were more knowledgeable about the decision than young people ($p<0.05$).

Residents living with others showed more positive reactions towards the need for preparation than single residents ($p<0.041$). Females in both areas showed a significant difference in their need to learn about mental illness in general ($p<0.003$) and to learn about the services available ($p<0.041$). Other responses showed minor differences but none was significant.

Again analysis of the study and control groups' answers over time showed marginal changes in the same direction, for example more respondents in both the study and control groups indicated the need for education after 6 months. Similarly both wanted information about former patients moving into their neighbourhood. Likewise, the study group were more interested in public education via the media in the second interview.

Content analysis for the data was carried out in the next section of the analysis of the results in order to describe the variation in local residents' answers.

1.9 QUALITATIVE ANALYSIS OF PUBLIC PERCEPTIONS OF QUESTIONNAIRE ON MENTALLY ILL PEOPLE

The strategy in this research was to use multiple sources of data and a variety of methods to test the same hypotheses and to examine local residents' perceptions of mental illness and mentally ill people. It also looked at their views about hospital closure and moving ex-psychiatric patients to their neighbourhood. Vidich and Shapiro (1955) and Tufte (1970) pointed out that the use of qualitative data in survey research could enhance the value of the data, contribute to greater confidence in the ability to generalise, and reduce any bias affecting the results.

Jick (1984) added that qualitative and quantitative methods of research should be viewed as complementing each other rather than as rivals. Duffy (1987) pointed out that qualitative and quantitative data should be evaluated in terms of their particular merits and limitations according to specific research questions. Webb et al (1966) identified the notion of a combination of qualitative and quantitative methods constituting "Triangulation". They added that the effectiveness of triangulation possibly rests on compensating the weakness of one method by counter-balancing strengths of another.

Denzin (1970) described four varieties of triangulation:

1. Theoretical triangulation; contains the use of several perspectives in the analysis of the same data.
2. Data triangulation; involves using a variety of sources to collect data to investigate the same phenomena in a single study.
3. Investigator triangulation; is the use of multiple observers, coders, interviewers and possibly analysts in a particular data set.
4. Methodological triangulation; is the use of two or more methods of data collection in a single study.

In this study the main obstacle encountered was handling and integrating numerical and verbal data to achieve comprehensible conceptual understanding of public perception of mental illness. Mitchell (1986) enumerated problems of analysis of such data as follows:

1. Combining quantitative and qualitative data;
2. Interpreting divergent results;
3. Overlapping concepts that emerge from the data and are not clearly differentiated from each other;
4. Weighing the sensitivity of various source of data; Mitchell (1986) suggested a possible approach to combing numerical and linguistic results: Firstly: analysing each type of data separately; Secondly: one merges the data either by a statistical or conceptual approach. That is to say, the different types of significant variables that are theoretically important.

Jick (1984) described general strategies to analyse qualitative data. These are: counting (incidents or consistency); noting patterns, themes; seeing plausibility; clustering; making metaphors; splitting variables; subsuming particulars into the general; factoring; noting relationships between variables; finding intervening variables; building a logical chain of evidence and making conceptual/ theoretical coherence.

In this study the conceptual approach was adopted in order to search for logical patterns of relationships and meaning in numerical and verbal data. This subsection is a collection of the verbatim answers of both the study and the control groups. The reasons for combining the results of both groups are: 1. There was no differences found between the study and the control groups in their replies. 2. To identify public perceptions of the mentally ill and their feelings about hospital closure in general.

After each interview a comprehensive account of the responses was written down. Then the accounts were subjected to a preliminary analysis to identify the main categories. The most common responses were selected and categorised under subheadings and main headings. The number of categories was reduced, following which major themes were identified.

It is intended to present this section in conjunction with the quantitative results. The objectives are:

1. To clarify how the local residents' responses were classified.
2. To give a flavour of actual words and phrases.
3. To discuss some of the methodological problems of the survey.
4. To illustrate and interpret the quantitative results.

1.9.1 Public reactions towards mentally ill people moving into the neighbourhood

When local residents were asked about their relationships with their neighbours, they expressed their opinions without hesitation even though in some instances these were negative. By contrast, when they answered the same question regarding their relationships with a mentally ill neighbour they were hesitant and seemed ambiguous in expressing their opinions.

Positive Public Reactions

Normalisation " Take him like anybody else. I would not treat them differently". They also expressed sympathy "I'll be sympathetic based on my personal experience" "would not shun them". Other reactions were expressed as handicapped views "Try to help them, talk to them, help in washing and shopping and give them some time" and contingent views like "I have to wait and see" "It depends on his behaviour" " A bit wary, I have to know them better" "As normal as anybody else, unless they start smashing or cause trouble They need to learn from other people" "I'll treat them as

they come. It depends how bad they are, some are frightened, so long as they are well enough to leave the hospital".

Neutral Public Reactions

Cautious distance "Do my best to be sociable - be a bit distant till you get to know them thoroughly and then leave them alone or talk to them". Anonymity of neighbourhood "It is not a close community here, we do not socialise and there is not much chance to communicate with our neighbours, so it does not make any difference to have mentally ill in the neighbourhood".

It seems that the local residents were willing to accept ex-psychiatric patients as neighbours as long as their behaviour is non-threatening to them.

Ambivalent Reactions

Trust and hope in professionals "The hospital would not let them out if they were dangerous. They could be better than a mugger" "I suppose the professionals know what they are doing, I will get them anything if they asked me. Anyway I would not know that he is mentally ill unless I'd been told. I feel sorry for them". Sympathy and fear "I'll be sympathetic, but I'll be scared. Mental illness is different types".

Negative Reactions

Fear of violence and unpredictable "I am on my own, mentally ill could be unpredictable. I am kind with neighbours, but with mentally ill, I will be wary". Avoidance of contact" I will not interfere, especially if they are violent.

From experience I have somebody living next door, set fire in his flat by putting things on the radiator. The police came and said do not interfere because he could be violent". "I heard about the rapist. So I would be cautious to answer the door" "I will keep away, especially schizophrenic, they kill you". A frequent negative view expressed by the local residents is dangerous to children "It is not safe for children, if by myself it is alright. If only disturbed, alright, but not if mentally ill" "I have children, they do not know how to deal with them" " They are unpredictable" burden on the public " Not very good idea. I have seen a mentally ill person. They could put pressure on you" "Children would copy him" " I do not think mentally ill people should be allowed out next to the public because they need 24 hours looking after" "These people need a special institution" "If they are relying on the public to look after them, I am an old woman and cannot look after anyone or help anyone" "Some families cannot cope with their mentally ill relatives in the community".

External factors that affected local residents reactions include media "According to the TV and seeing people in the street, they shout and walk up and down". Having a mentally ill person as a next door neighbour is likely to arouse anxiety for the local residents. This is because the mentally ill person was viewed as being aggressive, unpredictable and potentially disturbed.

1.9.2 Reactions towards a mental health facility in their neighbourhood

When asked about their reactions towards opening mental health facilities in their neighbourhood, local residents' responses were highly positive representing an enlightened attitude "It could be a chance to learn about mental illness because I do not know anything about it" "It help them to mix with people" "It is important to have mentally ill in our community.

Each community should reflect facts of life, we cannot shut ourselves off from them" " Lovely to have somebody to look after them".

Neutral Reactions

General "It is good for them to live in the community and find friends" "Local residents could use the facility"

Indifferent reactions

"I do not care" "They do not interfere with anybody" "Patients at The Grange are not violent and they are under supervision. The staff get them ready, no-one knows who they are and they are not a nuisance to people" "Advantage for them to find a place to live in, but it does not make a difference to the local people".

Contingency

"Does not bother me as long as they leave me alone" " I never run anybody down" "No disadvantage if they are not violent".

Local residents' opinions about their neighbourhood importance of the surroundings "Depends on the society and the way of thinking, might decrease the value of their property" "In this community, people are unaware of their surroundings unless something happens" "It is a nice community here, so that they can go around, but it could be a disadvantage if they endanger to themselves". Familiarity with mental illness "People will get used to it but it is rough area, might get mugged and picked on them".

Avoiding Ghetto

"Some kids could be nasty to them. It is better not to live together so that people do not treat them as different and label them".

Local residents showed an interest in having mental health facilities in their neighbourhood. They considered them as part of the services that should be provided by the government to improve the patients and their mental health.

1.9.3 What local residents could offer to a mental health facility in their neighbourhood

Local residents suggested the forms of help that former psychiatric patients might need from the public when they move to the community :

Psychological Help :

Acceptance this was expressed as "Accept them and be kind treat and them like anybody else" "Be friendly to them, visit them and go to jumble sales". Practical help "I can accompany them, organise entertainment, play piano. I'll enjoy it myself, make them feel wanted, they give you a lot of affection back. They make life meaningful" "I think I could do a lot to help. I can spare two hours a day to clear up and cook for them".
Tolerance: "Old age pensioners have got a lot of time, they can read and talk to them, they understand them more than the young people - who have no tolerance with them". Need professional help not lay contact "People are busy, and have children".

Positive reactions towards opening mental health facilities in the neighbourhood were expressed by the local residents' willingness to offer help and to maintain contact with these facilities.

1.9.4 Ways by which the local residents came into contact with the Grange residents

There was little direct interaction between the local residents and the residents of the mental health facility. Most interaction were as a result of the local residents' personal observation rather than the staff members' efforts to liaise with the local community.

Formal contact: "Knew about the Grange through working on the electoral register. The Grange was in his catchment area. I also saw the poster for Christmas Bazaar". Observation "Saw them filming the place, do not know what this place is for" "Seen them from the window - Something to do with the council, because I saw a van belongs to the council standing outside the building, but I did not know what that's for" "Seen them from the window, not wearing enough clothes, go out with slippers" "Seen them coming and going in groups" "All elderly coming and going in a coach".
Social/verbal contacts: "Seen them at GP clinic and in Jumble Sale. I asked a man as I passed the place" "Met the Grange people at the cafe, talk different, walk slowly and always smile".

Local residents opinion about the physical building of the Grange was outstanding building " Don't see the patients, could have built a block of flats in place of that big building" " They do not need such a luxurious place - not good to train them in such a place and expect them to live independently. Most probably they are frightened to walk on the carpet. It should be ordinary where they are going to live to make allowance".

1.9.5 Needs to know about the opening of mental health facilities

On the one hand, local residents pointed out that the reasons for wanting to know about the opening of mental health facilities in their neighbourhood were information is a helpful action "might give an opportunity for some residents to participate" "If I'm told, I

can explain to my children and understand why they behave like that". Useful resource for local residents " If I have got a problem I might use it".

On the other hand, local residents warned about spreading information about the opening of mental health facilities as information could lead to protest" If we are told, we know exactly what to do, some people could be for it or could be against it. I would not say no or object" "I need information to take precautions I have 4 kids, I will worry". Information could lead to prejudice "No need, if got to be told should be done in a subtle way. People might expect danger, they will think negatively about it". Information to protect the children". A mother with young children should know what to do, not to let their children play outside alone near the place".

It seems that the local residents were keen to know beforehand about the opening of any mental health facilities in their area, partly to be aware of the local facilities and partly to prepare themselves and take precautions.

1.9.6 Concepts of mental illness

It was felt that the local residents answered this question from their previous experience or what they had learned from the media rather than from their contacts with the patients who moved to their neighbourhood.

1. DIAGNOSTIC CONCEPT

Psychological Condition "There are different types of mental illness like manic depressive" "Mental illness is when one has two personalities" "Mental illness is something in the person's mind, with vast imagination" "It could be a split personality" "It is a severe condition of nervous breakdown" " It is a psychopathic state" " It is a depressive state" "It is someone who has both nervous break and mental illness" " After I lost my mum I got the condition. I went to the Maudsley Hospital and lost my job and could not pay my bills and lost my friends".

Neurological Condition "It is a nerve disease like epilepsy". Confusion with mental handicap "My nephew is spastic and mentally retarded" "I know somebody - cannot read or write, cannot tell the time, aggressive, difficult to handle".

Confusion with physical Illness "Mentally ill is a spastic person".

2. SYMPTOMATIC

Strange "Mentally ill is someone who talks incoherence, irrational and not in touch". Serious condition " Mental illness is very difficult. The brain goes completely the other way - my sister after an accident to her son, she started to throw furniture and became changeable". A disease "It is a disease". Vague condition "It is a state of doze like sleep-walking" "Somebody not only looks strange, but talking strange and living in a world of their own" "Do strange things" depressed state "I have got the condition - I get panic, lack of hope and depression".

3. CAUSAL

Brain damage "It is a disease that damage the brain. I saw them on 221 bus, they dressed strangely, don't pay on the bus or show their bus pass".

4. BEHAVIOURAL

Disturbance to the public "A friend exposes himself - does silly things in the road. He went to the hospital prison and said he is mentally ill".

Not different from us "Normal as us, my brother-in-law due to war, he became mentally ill"

Out of control "Uncontrollable mind and change in personality".

Lacking social skills "Is vague, mentally people have bad habits, pick or scratch".

Infantile "My sister when got the illness went like a little child. She is the eldest but she depends on me. Never got better for 30 years".

Naming the illness "I took an overdose, I get sick of life. Doctors called me mentally ill. They could not differentiate between losing temper and mental illness". *Unpredictable* "My uncle was one minute shouting and raving and next minute calm - he used to drink a lot of alcohol".

It has been noted that mental illness was conceived of as a serious and dangerous condition. The majority considered mental illness as a different and strange condition, the cause of which is unknown or due to permanent changes in the brain. Local residents who had experience of mental illness were likely to describe mental illness as a non serious condition and identify an external reason-mainly social, for the illness.

1.9.7 Public opinions about the causes of mental illness

Local residents showed a tendency to express psychosocial and physical views about causes of mental illness such as:

Social Causes " divorce, problems in the family" " when life gets on top of you". Stress "Overwork" "over reading" "a lot of thinking"

Modern living "Fast Life".

Social Disadvantage "unemployment" "Lack of money".

Upbringing "Depends how you treat your children".

Personality "Lack of confidence" "Excitable type" "Unpredictable people".

Criticism "Drop on people's heads".

Pressure "a lot of problems and thinking"

Brain abnormality "Brain not functioning".

Head injuries "brain damage during birth"

Chemicals Intoxicants food "food additives, alcohol".

Physical illness "Lung disease, stroke, german measles, cancer" "High blood pressure"

Politics "Politicians when they enforce rules and bad economic news".

Heredity "Something deficient in the make- up as for example in the genes, then something triggered it off".
Addiction "Excessive drinking, drugs and sniffing glue".
No reason "Snaps" "it could happen instantly" "Some people more susceptible than others".

1.9.8 Public identification of the mentally ill from behaviour

Local residents indicated that mentally ill people are characterised by the following behaviour:
Unpredictable "You cannot really detect mentally ill people unless they do some actions, sudden outbursts of anger, illogical thinking, it is too difficult to detect like murders".
Violent "Rapist".
Antisocial "Living in a world of their own" "Lack of inhibition" "Beggars" "sponger".
Poor communication skills "Speak loudly", "slurred speech","talk a lot", "Incoherent, hallucinate".
Bizarre "different", "odd", "walk differently", "eyes roll back", "standing in one place talking to themselves", "facial expression", "Cry for no reason", "Cannot understand", "Irrational".
Addicted "Drinks a lot of tea and coffee" " Heavy drinker".
Poor social skills "Dirty clothes", "dribble", "swear".
Inadequate Personality "Nervous", "withdrawn", "panic", "jumpy".
Slowed-down "Unicellular", "slow in actions", "always fall behind".

Local residents seemed to stereotype a mentally ill person by associating him with physical, psychological and mental characteristics. These characteristics were all negative. They identify the mentally ill person as deviant, socially distant and aggressive.

1.9.9 Opinions about mental hospitals

Local residents who are in favour of mental hospitals claimed them to be the most suitable place for treating mental illness. However, local residents who were unfavourable towards mental hospitals, criticized them for their physical settings, their treatment and negative attitudes of the staff.
Psychiatric hospitals are the right place for psychiatric patients "Helpful and needed otherwise all patients will be in the streets".
Protects society " Mental patients feel bad against society, but at least in hospitals they are isolated from society".
Frightful "Friern Barnet has long corridors and locked doors and is frightening" "There are some patients in the mental hospitals who should not be there"
Poor treatment "Inadequate. just for preservation of life, poor staffing" "Disgusting, dirty, put patients in long corridors and give them tablets" "Impersonal, some hospitals so large,

unaware of patient's problems and leave them for years" "Beat the patients up, unkind, noisy, and torment" "Drugged you up, patients just sitting completely vacant. Give Electro-convulsive therapy to make people like zombies".

Ambivalence "Sometimes treat patients with cruelty - but these people need somewhere to go for treatment".

Stigmatise "Frightening, I am afraid of going in and not coming out and being drugged up and stigma attached to them".

Media's role "Do not know, having only distorted picture of them. From the TV it is frightening".

1.9.10 Public choices between community care and hospital care

When local residents were asked about the type of treatment they would choose if they become mentally ill, the majority of them pointed out that the choice of the type of their treatment depends on their General Practitioner. "All depends on the GP" "It depends on the severity of the condition". When asked what choice they would make if given the opportunity, those who chose psychiatric hospital treatment gave the following reasons:

Institution is a safe place "I might hurt myself at home - I do not like to be by my own". Hospital admission help to change environment "The cause of illness could be at home, that is why it would be better to go to hospital".

Hospital protects society "Psychiatric hospitals away from people, I do not want to be a nuisance for anyone". Hospital is a reliable place "I prefer psychiatric hospitals, I sometimes forget to take my tablets or forget to tell what happens".

Hospital is competent "In the hospital you get over the condition quicker than seeing the G.P."

Community care is isolating "I live by myself - I'll prefer the hospital where many people around me".

General hospitals are less stigmatized "Psychiatric hospitals know better than general hospital" "Psychiatric Hospitals are specialised and have the experience".

Lack of support in community care "I do not expect my husband to look after me".

On the other hand, those who chose community care, gave the following reason:

Community care is a normalised treatment "The more normal your life, the easier to bring the mental attitude back to normal" and "Reduce stigma of mental illness".

Local residents who were in favour of psychiatric hospital treatment considered it a secure place to be professionally and socially when they are mentally ill, while local residents who preferred community care, considered it more normal than hospital treatment, wanted to be in a familiar environment and considered it less stigmatized.

1.9.11 Public opinions about community care

Local residents showed various reactions toward community care:
Realistic views of community care "Good with preparation" " Community care is a good decision but some patients will always need hospital care" "If they are experimenting to see whether or not community care is working O.K. providing that they are using experts in the process, but not to shut the hospital just like that. Hospital closure will affect the health and welfare of the nation. I am against hospital closure anyway".
Preparation for community care "In the hospital, they do everything for them all the time. They would not bother and difficult to send them to the community straight away" "It should be a gradual process, they should live in a hostel first and when they get better they could live in the community. Otherwise, the public will do them more damage".
Inadequacy of community facilities "There are no doctors in the community 24 hours like in Friern Barnet" " Mentally ill people need a secure place all their life" " G.Ps do not understand about mental illness" "From experience, homes for former psychiatric patients not providing enough services because of lack of money" "They should increase acute admission wards, community psychiatric nurses and a good after care" "Lack of qualified staff in the community will mean that the patient ends up in bed and breakfast" "These patients are instituted and need their social network and a lot of preparation".
Consulting the public "Short-sighted decision, and they did not ask people's opinions about it".
Community care is politicians' interest rather than public interest "Even if most people were against closing Friern hospital, the government would not reverse the decision" "People are doing it for financial reasons. If Friern hospital closes, patients would pack up and die" "Disgusting - just to save money" "These patients will have to walk the streets and get in trouble" " Perhaps it could be a good idea if some patients from Friern hospital moved next-door to 10 Downing Street and then ask Mrs Thatcher how she feels".

Many residents seemed outraged about the decision to close psychiatric hospital and patients moving into the community. There is confusion about the purpose of community care, as well as alternatives to hospital closure. There were mistrust and blame expressed towards the politicians. The reasons for these feelings seem to be:
1. Deprivation of the public of their right to have services available for them to use when they need them.
2. Loss of the institutions they thought were always there to protect them from the dangerousness of mental illness.

1.9.12 Public reactions towards the ability of discharged mentally ill to live in the community

Local residents showed reserved reactions towards patients' ability to live normal life outside the hospital. Proper preparation and continuing support were considered essential for patients' adjustment in the community. this was expressed as follows:
Ability to live independently "Yes of course they can, the stigma is carrying out of the hospital".
The need for support "Under supervision because they don't take their tablets regularly" "Need a friendly neighbourhood".
Contingent " Give them the chance, we have to wait and see if they could cope" "Depend how long they have been in the hospital".
Generalisation from negative experience "Dad's neighbour is mentally ill, steals milk, shouts, swears, threatens them with a knife" "They can if they don't hound other people".
Negative reactions expressed as "Mentally ill do not get that well to live normal life. Condition comes from God, cannot be cured 100%".

1.9.13 Opinions about the type of accommodation required

Local residents suggested the following types of accommodation for former psychiatric patients:
Independent accommodation "In a normal everyday environment".
Sheltered accommodation "I do not believe in big ghetto, but they are better together, 4 or 5 in a supervised home like the little crowd down the street" "A foster family to be in normal atmosphere".
Support in proportion to disability "Depend how bad they are, obviously they will need help".
Gradual preparation "A hostel first then back with their families. Should not be left on their own".
Special arrangements for accommodation "Ground floor flats so that they don't feel isolated and people can look after them" "In a flat or a house in a friendly neighbourhood, where they can be visited". "Should live in groups to get support". *Avoiding stress* "A quiet, peaceful area in a private house. With someone to check on them from time to time".

It can be concluded that mentally ill people were seen as vulnerable and a danger to themselves, therefore, local residents considered professional support and special kinds of accommodation were essential.

1.9.14 Public reactions to working with ex-psychiatric patients

Local residents were cautious in their opinions about working with former psychiatric patients:

Positive reaction "I'll enjoy it" "I get satisfaction from helping others". Normalisation" Would not make any difference".

Disabled from full work role "Depend on their behaviour". "I'll understand their difficulties".

Conditional acceptance of working with former psychiatric patients "I would not mind as long as he is not harmful". Cautious "I'll keep an eye on them and be careful".

Negative reactions Fear "I'll be apprehensive with schizophrenics".

Avoid working with them "I cannot cope with them".

It seems that local residents viewed mentally ill people as unfit to carry out a normal job and stated conditions to work with them. Even though some of the residents showed willingness to work with former psychiatric patients they did not consider them as equal work partners.

1.9.15 Preparations required by the local residents before psychiatric patients move into their neighbourhood

These were:

Background information about the patient "How dangerous they are" "If they are violent, educate the public, if not, do not bother" "If there is a school in the area, public will need to know" " Warn people who have kids".

Types of supervision they have "What types of patients? What supervision are they having?" "What is wrong with them? and if they collapse what telephone number to ring for emergency?"

Knowledge about the facilities available and how to help "It is important to tell the public because they will get cross if they just move the patients in. They will get used to the idea and accept them".

Information about the facilities "What sort of facilities and invite people to see what is happening" "The location of the facilities".

Uncertainty about public preparation "Preparation of the public could be a two way process. The public might react negatively or might educate them".

The reasons for not wanting preparations were:

Patients' care is the professional responsibility "As long as there is staff to look after them, no need for preparation they have got to live somewhere".

Education should be directed to people concerned "No need, only people who will be affected by their discharge, those who are not affected would not bother to listen. "Adverse reaction to education "No need for preparation there is enough prejudice already, they should be left to live normal life" "It could frighten people off like AIDS"

"If you educate the public, mentally ill people could easily get condemned" "It would worry people more if things started coming through the letter-box".

Lack of interest "I am not bothered, better educate children at school" "Public are not ready, not interested to know. Live for themselves unless people affected directly they would not be interested".

Power of others "They will move them and there is nothing we can do about it, if that person is desperate for somewhere to live" " It is up to the Council not up to us".

It can be concluded that local residents who did not want any preparation or could not decide about what they needed: (1) expected that the professionals would take responsibility for those patients, (2) were concerned that the preparation might induce fear of mental illness, as AIDS, and (3) were not interested in community care. However, some local residents wanted basic information about patients moving into their neighbourhood, the type of facilities they are moving to, and knowledge about mental illness in general.

1.9.16 Public suggestions for the contents of educational programmes

Local residents showed a great need to learn about mentally ill people and how to deal with them. This needs expressed as:

Information about the disease " What is mental illness? What they do?" "How mental illness starts?" "How it affects people? Why some people get mental illness and others do not"

Reassurance "Convince the public that there is no stigma, mental illness could happen to anyone. When I went back to my work people treated me well" " I am not sure whether it is wise to educate the people or not, it is worth trying" " Reassure the public about mental illness that mental illness not dangerous or psychopath. Mentally ill could be disturbed from time to time. Mental illness like any other illness. Encourage the public to accept mentally ill as part of the community and take a positive approach, as for example patients should not be singled out".

Facilities available "Various types of treatment, mental illness facilities".

How to approach mentally ill people "Tell people roughly the kind of pressure mentally ill have been through" "Tell people that mental illness is a black out, inability to control yourself, and to think only in one specific thing" " The two mentally ill downstairs one day talk to you and next day don't know you, I would like to know how to approach them".

Acceptance "Try to accept them better and not let them feel as alien" "Explain to people that mentally ill people are not dangerous, behave rationally most of the time, and they are capable of carrying out normal life" "We may all need psychiatric treatment some time in our life, so treat them as human beings and do not walk away" " Mentally

ill are not raving lunatics, teach them what is happening in the hospitals instead of keeping it a secret."

While most of local residents showed a great need to learn about various aspects of mental illness and mental hospitals, a minority considered information about mental illness could lead to negative attitudes towards the mentally ill.

1.10 DISCUSSION

The main objectives of this research project were to study psychiatric patients, staff who were looking after them, and local residents' reactions towards closing Friern and Claybury hospitals and moving former patients into their neighbourhood. It also aimed to identify problems that may arise during the intermediate period of 6 months after moving into the community.

1.10.1 Discussion of the public attitudes study results

This section will discuss the findings of the study under the following headings: a. Methodological critique of the study b. Reactions to the interviews. c. Relationships between the characteristics of the public and their perception of mental illness. d. Public perceptions of mentally ill people. e. Popular attitudes toward mental illness. f. Public opinions toward community care. g. Community mental health services. h. Public needs for preparation before former psychiatric patients move into their neighbourhood.

1.10.2 Methodological Critique of the Study

1.10.2.1. Nature of the questionnaire and interview

The questionnaire in this study was piloted and constructed on the basis of information derived from open-ended interviews. It is possible that the researcher may have introduced a bias in scoring open-ended questions, such as characteristics of the interviewer, manner of speech, expectations, attitudes, and anticipation of the results. However, this potential source of bias was minimised by recording the actual verbatim answers, verifying the level of agreement with another interviewer and by seeking the opinions of two experts in the field concerning classification of the results.

1.10.2.2. Response rate:

Bias can be introduced by non-respondents in the first and second interviews. It is possible that members of the public with more negative attitudes were reluctant to answer questions about the mentally ill. However, the characteristics of non-participants were checked and showed no significant differences between respondents and non-respondents in the second interviews. In the first interview, 28% refused to be interviewed. This

population could be a potential source of bias if they were more negative in their attitudes.

1.10.2.3 Lack of change in study and control groups over time:

The results of this study showed no significant changes in public attitudes. It is possible that this is a Type 2-error due to : 1. small sample size, one of the reasons is that many addresses were occupied by a transient population. Future studies should be at least 20% larger in size than the present study in order to show differences in attitude
2. The second possible reason could be lack of sensitivity of the research tool. However, the RG has been demonstrated to be sensitive to change in attitude, e.g Orely & Leff (1972).albeit on small group of respondents and has confirmed the findings of the semi-structured interview.
The lack of change in public attitudes could be a genuine finding, in which case it might have been unrealistic to expect change over a short period of time, especially in view of the fact that the patients were protected from contacting members of the public by the staff.

1.10.2.4 Limit to generalising results

There is a limitation in generalising the results because the study sample is homogeneous, being working class only. Therefore, future studied should include a middle class area.

1.10.2.5 Two other methodological issues pose difficulties in delineating attitudes toward mental illness, namely 1. response bias of the local residents to the questionnaire; and 2. the relationship between expressed attitudes and behaviour. 1. Response bias: The first question that arises here is do the responses to the questionnaire study accurately represent public attitudes? Other studies such as Link (1987) and Link et al (1987) suggest that respondents may answer some questions in the way they think the interviewer wants or may give socially acceptable answers leading to a bias response. In the present study the reliability of self-report data was an issue. One has to say that while some responses may have been made to look socially acceptable or conform to moral values, some answers appeared to contradict others, as discussed in detail in the results and later in this section. During the interviews, response bias was minimised by asking questions that would check and clarify certain answers. Moreover, data from patients' and staff members' studies supplemented the material from the residents' questionnaire, and helped to extend the findings beyond a simple description of the results.

The question of internal and external validity should be addressed in relation to change in attitude. In this study internal validation of the measures was achieved by careful construction of the semi-structured interview items and by including the Repertory Grid Technique, which is subject to minimal bias. One also could argue that

since both positive and negative attitudes emerged there is unlikely to be a substantial response bias. Furthermore the RG results are similar to the questionnaire findings.

The use of a semi-structured interview questionnaire in combination with other instruments proved to be a successful method of identifying public attitudes and providing data that are rich in detail and have not been available before. The interviews encouraged the respondents to express complex attitudes towards mental illness. Moreover, other factors emerged that might affect public reactions to former psychiatric patients such as the moral and charitable attitudes of the general public, reactions to the decision to close psychiatric hospitals and perception of mental illness itself.

1.10.2.6 Expressed attitudes and behaviour:

The second question that arises is did local residents' expressed attitudes accurately reflect their behaviour toward former psychiatric patients in their neighbourhood? One could argue that for reasons of social acceptability there may be a discrepancy between stated attitudes and actual behaviour. This is a problem that affects all questionnaire studies and the assumption that people feelings are directly translated into actions has rarely been demonstrated. However most questions in this questionnaire related to overt behaviour in addition their feelings, which might overcome some potential bias. For example, local residents' responses concerning their beliefs about the dangerousness of mental illness did not affect their responses regarding the possibility of using mental health facilities. It was also possible to check on the validity of the responses in another way: while the shopkeepers expressed positive reactions by attending the open day and were agreeable to patients trading with them, very few neighbours were present at the open day and none of the local residents were among patients' social networks.

One could argue that in order to identify the local residents' attitudes that reflect their behaviour toward former psychiatric patients moved into their neighbourhood, observational studies should be carried out on the public's actual behaviour.

1.10.3 Reaction to the interviews:

It was surprising that the local residents reacted positively to the door-to-door interviews, an opposite response to what most administrators and project planners expected. Each interviewee spent 30 minutes or more discussing issues related to psychiatric illness. Only one third of the interviewees were lost in the second interview. In addition, the local police informed me that two women posing as social workers had broken into a few old people's flats and that the police had warned the local residents not to open their doors to any strangers just before the beginning of the research interviews. One could explain the local residents' interest on the basis that they had been offered the opportunity to air their views on a subject that is often feared, and that they felt a

responsibility to give an opinion and the need to understand the topic and to participate in their local area affairs. This interest was expressed as: 'the government should send an independent investigator from the health authority to find out about people's opinions and tell them the facts' 'it is just the time to seek people's opinions, they should have started long ago' 'research could be one way to help people to release their anger before moving patients in the community' 'research is better than ignoring the public altogether'.

1.10.4 Relationships between local residents' characteristics and attitudes towards mental illness:

Participants' sociodemographic similarity in this study seemed to be reflected in their attitudes toward the mentally ill. Few significant differences in their attitudes were found.

Ramsey and Seipp (1948), Woodward (1951), Cumming and Cumming (1957) Lemkau and Crocetti (1962), Phillips (1966), Johannsen (1969) and Laine and Lehtinen (1973) demonstrated similar results regarding the way in which variables like education, age and social class affected attitudes towards mental illness. That is to say the higher the educational background of the subject and the younger s/he is, the more positive are his/her attitudes towards mental illness.

However, recent studies in the field could not identify such distinctions, for example Heller et al (1980) concluded that mental health attitudes are not related to sociodemographic variables.

The effects of sociodemographic characteristics of the local residents in this study will be discussed as follows:

A. Contact with mental illness:

The results of the study showed that casual contact of the local residents with The Grange residents had little or no effect on public attitudes. Local residents with less contact with mental illness were likely to ask for more information about mental illness. High contact levels of most of the local residents (due to contact with a relative who is mentally ill) seemed to have affected their recognition of mental illness more than personal variables. It was interesting that the local residents described symptoms of mental illness of their relatives as nervous breakdowns even though they had identified psychiatric symptoms matching to their description for their relatives.

B. Age: The younger age group was slightly more inclined to consider that the majority of patients could be cured.

C. Sex: Females in both areas showed a significant difference in their need to learn about mental illness in general and to learn about the services available. Females with children showed more interest than females without children.

Even though wives and single people were highly represented, this tendency has not affected their attitudes significantly. In contrast, Link and Cullen (1983) and Green et al (1987) showed that female students were more likely to have positive attitudes than male students. While Fletcher (1969) found little class difference in attitudes towards mental illness.

Females showed statistically more negative attitudes than males. One could explain females' interest to learn about mental illness as due to their anxiety about their children getting hurt by the mentally ill. However, some female respondents indicated that they would like to learn about mental illness to teach their children how to deal with various situations that might arise with former psychiatric patients.

D. Household characteristics:

Residents living with others showed significantly more positive reactions towards preparation before former psychiatric patients moved than residents living alone. This result could be due to the fact that they felt more secure about being approached for educational purposes if they were sharing accommodation. Moreover, households with children wanted more preparation because they were worried about their children.

E. Characteristics of the neighbourhood:

These two areas of the study showed that despite the physical closeness between neighbours in the area, residents have as little as possible to do with one another. This type of community is unlikely to notice the presence of a new group such as The Grange. Housing conditions such as high rise flats and squatting can also influence the pattern of interaction among people who live in close proximity. McGahan (1972) found that residents in single family homes interact with their neighbours more frequently than high-rise flats residents do.

Moreover, they emphasized the anonymity of the neighbourhood and expressed cautious views towards former psychiatric patients as neighbours such as "I have to wait and see" "It depends on his behaviour" "A bit wary, I have to know them better".

1.10.5 Public Perception of the mentally ill

The findings of this study are similar to those of the study carried out by Yankelovich (1989) in 9 cities in U.S.A. who conducted in-depth telephone interviews with approximately 1,300 Americans, representative of the total adult population. He found that a high percentage (31%) reported experience with mental illness. Similarly in the present study 19% of the study group and 11.7% of the control experienced a mental condition during their life and 39% of the study group and 25% of the control group have a relative or knew somebody with mental illness. Six out of 10 indicated the need to learn about mental illness, likewise in the present study 90% indicated the need to learn about mental illness. Similar to the present study Mass media were the public's primary source of information about mental illness. Their perception about mental illness was:

74% thought that it could be cured. Similarly in the present study mental illness was viewed as more curable than other physical conditions, 29% in the study group and 28% in the control group. The American public similar to the British sample believed mentally ill people could live a normal life 54%.

While in the present study the majority of the local residents viewed mental illness is different from physical illness except in the need to hospitalization, the American public 43% considered that mental illness is not different from any other illness. Regarding the causes of mental illness, 91% said it was caused by physical disturbance (chemical disturbance) 90% environmental conditions (daily stress); and 93% identified alcoholism/drug abuse. In the British sample 27% of the study group and 24% of the control group thought that mental illness caused by physical disturbances, 83% of both groups indicated that metal illness caused by environmental factors, 27% of both groups said it is caused by chemical substance, drugs and alcohol while 39% of the study group and 34% of the control groups said it is a hereditary disease.

In the present study mental illness was perceived as being only of two types: "schizophrenia a serious disease and "depression or nervous breakdown" which is mild and curable. Local residents' perceptions of mental illness will be discussed in relation to the different attributes of illness:

A. Identification of mental illness:

Symptoms of mental illness appeared totally incomprehensible, strange and mysterious to the local residents than physical illnesses such as diabetes. This confusion was expressed as " mentally ill person is somebody with split personality, has something in his mind and with vast imagination" "it is a state of doze like sleep-walking".

The mentally ill person was perceived as not complying with normal expectations, he needs others to always adjust to him and look after him, therefore he should be under 24 hour observation in a hospital. Mentally ill persons were associated with crimes against vulnerable people, such as children and the elderly. However, physical illnesses such as diabetes and epilepsy were not stigmatized even though they were perceived by the public as having psychological aspects and a chronic cause, and being incurable, but not incomprehensible compared with mental illness.

The negative aspects of the public's perception of the former psychiatric patients moving to live next door might hinder patients' full adjustment to living outside psychiatric hospitals. The public differentiated sharply between problematic behaviours that should be regarded as illness and those that should not. They also distinguished between problems that should be called "mental" and "emotional". Similarly, Bord (1971) and Phillips (1963) found that severe disorders and bizarre behaviour are more likely to be identified and rejected than less abnormal behaviour.

Local residents were also likely to make a distinction between "madness" and "mental illness", particularly certain forms of illness such as depression, and nervous

breakdown. A vagrant and a person with alcohol problems seemed to be perceived as similar to the mentally ill. The diagnosis of schizophrenia was the illness label which the local residents were most afraid of and showed rejection towards.

Local residents gave contradictory views concerning mentally ill and mental handicapped people. While more than half of the participants could not differentiate between the mentally handicapped and the mentally ill, at the same time, in other sections of the interview they expressed extreme negative views towards the mentally ill but sympathetic and positive views towards the mentally handicapped. This sympathetic view towards the mentally handicapped appeared in their willingness to donate money to charitable organizations for mentally handicapped but not for mentally ill people. However, they also were unwilling to rent a room to both of them because the mentally handicapped person would need somebody to look after him all the time, while the mentally ill person is dangerous and unpredictable. This reaction could indicate that the public's negative attitude toward mental illness is based not on their contact with former psychiatric patients in the area but on their preconceived ideas about mental illness.

B. Causes:

Local residents significantly differentiated between nervous breakdown and mental illness in terms of causation, severity and curability. For example nervous breakdown was believed to be caused by simple everyday problems such as family stress, pressure at work, death of a loved person, while mental illness was seen to be caused by heredity, organic conditions, and longstanding stressful situations.

The majority of respondents identified social factors as one of the main causes of mental illness, such as divorce, death in the family, unemployment, high work load, poor housing conditions, stress and pressures of life. One could say that if stress was considered to be a common cause of mental illness, then action for prevention of illness could be taken by the general public in order to prevent stress. This view could be considered a positive step toward accepting mental illness as a disease that could happen to any one.

C. Prognosis of mental illness:

It was surprising to find that there was a consistency between the study and the control groups in perceiving mental illness as more curable or controllable than any of the other chronic conditions. Twice the number of people saw mental handicap as incurable as did mental illness, but still a large number believed that successful treatment depended on the condition or the causes of the illness.

D. Severity of mental illness:

It seemed that "serious" behaviour which threatens the person's social and psychological security is the most likely to provoke the people's judgement of the severity of the illness. Blizard (1968) found that those who did not view the psychiatric illness as

"serious" based their opinions on the absence of violence, the absence of threat to others, the ability to look after themselves, and the curability of symptoms. Star (1955) added that only those showing bizarre behaviour and obviously psychotic persons were viewed as "sick".

On both occasions, local residents tended to regard mental illness as dangerous. This study found that local residents judged the seriousness of mental illness mainly on the basis of their preconceived ideas about mental illness which they obtained from the media or just on the stigma of mental illness and the lack of mental health facilities. Similar results were obtained by Main et al (1989) who found that the public's negative attitudes were due to their judgements about behaviour which had been described as socially and physically threatening to people around them, especially to children.

One could argue that the transfer of psychiatric services into locally based services could contribute to reducing the stigma attached to mental illness if various opportunities were taken by the staff of each facility to approach local residents and encourage their acceptance of the presence of former psychiatric patients.

One could sum up local residents' views concerning the recognition of mental illness as based on symptoms of violence, physical assault, difficult communication or irritability. Describing mental illness as bizarre may be rooted in local residents' confusion about the cause and treatment of mental illness about which they expressed lack of knowledge and understanding.

E. Opinions about treatment of psychiatric illness:

Most of the local residents valued activities and contacts with the staff at psychiatric hospitals, which could be interpreted as stemming from their lack of awareness of alternative facilities to hospital care. Psychiatric hospitals were still considered to be needed to protect the community, as patients recover better there. Even though half of the respondents had heard about closing hospitals in general, the majority did not know about the closure plan for Friern and Claybury hospitals. They strongly objected to the idea of closing psychiatric hospitals, and it seemed to be an important issue for the public. Such feelings are inevitable when such a large local hospital is closing down.

The policy of deinstitutionalization is supported by the results of some studies of patients' progress in the community. However, the results of these studies were not used to reassure the public about the effects of community care.

Even though there was high contact with psychiatric hospitals it seemed that the ability of staff to care for patients in the community was not perceived as related to the effectiveness of their treatment in hospital.

In addition, community care was viewed as segregating patients. The more contact respondents had with mental illness, the more likely were they to recommend a wide variety of treatments such as out-patient clinics and hostels.
One speculative explanation for such findings is that the label attached to being treated in a psychiatric hospital acts as a deterrent to local residents. It was surprising that respondents were willing to let their friends and relatives be treated in a psychiatric hospital to avoid any responsibility for looking after them, but not for themselves to be so labelled.

1.10.6 Popular attitudes towards mental illness:

Psychological research showed that not all attitudes are deeply embedded, and established a distinction between three classes of attitudes:

A. Some individuals have attitudes that are flexible and manage to adjust to social reality with little friction. Their attitude remains their own and is not determined by surrounding group norms.

B. Attitudes that form an internal integration that is rigid; the individual does not know or care what the facts are. These attitudes are unlikely to change.

C. Attitudes that are lacking a firm structure and shift in response to the immediate situation. This type is susceptible to education, to mass media and to rewarding experiences. One could say that the local residents' attitudes fall into the last category.

A major finding for all local residents interviewed on both occasions was the fear of the "mad" - meaning out of control and unpredictable. The strength of feeling of the local residents about the issue of the stigma of contact with former psychiatric patients as next door neighbours was so great that it often emerged spontaneously in the interviews.

Mentally ill people were viewed with anxiety and fear. In contrast the mentally handicapped evoked pity and sympathy. The local residents used the label "mental illness" for limited varieties of behaviour such as schizophrenia and depression. The labelling effect was also stronger when the respondents gave answers reflecting their perceptions of what most people believed about mental illness.

A view underlying most of these negative attitudes is that former psychiatric patients inevitably produce the very effect that respondents described as unsafe and dangerous. Tardive dyskinesia syndrome, for example, could cause fear to the public who are unfamiliar with the signs which they described as "nervy" "shaky legs" "jumpy" "have funny face" "their eyes roll backwards".

One could add that the rising crime figure rate is ascribed by some people with negative attitudes towards community care to the discharge of mentally ill patients into the community, this being more likely to put professional efforts in jeopardy. Some of the interviewees described psychiatric patients as "carrying knives" "rapist" "molesters"

Local residents described psychiatric patients as "wanders about" "different", even though this does not affect the public and it is quite all-right for people to walk in the streets and to wear clothes that are shabby or out of fashion. These are important results because they show that a significant portion of the local residents were likely to reject patients resettled from a mental hospital.

Public attitudes of fear and ignorance should not be neglected and are to be taken seriously. Positive public attitudes can only be achieved by appropriate educational programmes. Precautions should be taken that the public, as they cannot direct their anger towards the decision makers, may vent it on former psychiatric patients. The issue is illustrated more concretely by an incident recorded in the Guardian newspaper on Wednesday, 22 August, 1990, when the residents of North West Southport tried to prevent a house bought by The National Schizophrenia Fellowship being used as a home for 15 schizophrenic patients and a day centre for seven more. The neighbourhood opposition was based on fears about: unpredictable behaviour, and the safety of the children, and the presence of two other homes for elderly and mentally handicapped. Another resident objected because the increasing number of visitors to the area would make the facility like a mini hospital. The residents indicated that they would not mind if the house was used for mentally handicapped people. The article describes an incident where one of the residents got hold of one of the patients and shouted at him "we do not want any dick-head living near us". In Chiswell Green, Hertfordshire, four families together bought a house to prevent the local Health Authority purchasing it as a group home for the mentally handicapped. Similarly, in Bath a legal clash occurred over an alleged breach of a covenant by the Health Authority.

One can detect a message of rejection in the language used by local residents in this study such as "odd, like a zombie, berserk, vague, funny". There are also instances of other perhaps less obvious, negative attitudes and beliefs about mental illness, for instance 3/4 of the local residents said that they would attend a club which former psychiatric patients are also attending, however they showed little interest in socializing with them and explained their reluctance as follows "I am not a sociable person anyway" "I'll attend as long as it is a club for other people as well" "I will not attend by my own I'll take company with me" "depends on the percentage of mental people attending there" "I'll go if I am going to do something to help them". Similarly they laid down condition for working with former psychiatric patients such as "If the work does not involve sharp instruments" "if he is receiving enough help or support from the hospital" "I would work with him but would not wish to share a business with him". Moral views were expressed such as "I will never stop anybody from earning a living". Likewise Link and Cullen (1983) proposed that ideal/moral attitudes towards mental illness were more positive than expressed or acted and deep attitudes. It is possible that an individual is rejected for behaviour that is harmless but perceived as "strange".

Attitude Change

The findings of this study revealed little evidence of change in public attitudes after 6 months. One could suggest that contact of the public with mentally ill people is unlikely to induce change. A number of researchers such as (Holmes,1968; Pryer et al, 1969; Hazleton et al; 1975) demonstrated that education of the public is necessary to change their attitudes. Wahl and Lefkowits (1989) pointed out that corrective information could also counteract the effects of the stigma of mental illness.
Similarly, there was little evidence of change in public attitudes during the course of 6 years between the initial surveys of the 'Hurt Mind' and the Northamptonshire studies in the U.K.. Although there was some increase in the numbers of respondents who were willing to tell people about family members who were mentally ill, a substantial minority in both surveys said that they would endeavour to maintain secrecy. Perhaps legislation concerning the provision of education and information about mental illness to the public if enforced on planners and managers, could have an indirect effect in reducing personal prejudice.

1.10.7 Public attitudes to community care

The results showed that the public expressed anger, fear, ignorance and suspicion, and a sense of helplessness toward the politicians' decision to close psychiatric hospitals. These attitudes should not be ignored. Community care was viewed as in the politicians' interest rather than the public interest. On the other hand, they expressed confidence in professional judgement by stating "that they would not discharge anybody who still needed hospital treatment". They considered that psychiatric patients need professional help rather than lay support and that community care would burden the public.

Some interviewees tended to generalize from their negative experience with psychiatric patients who are not under professional supervision, that is vagrants and people with alcohol problems in their area.

Local residents also expressed ambivalent reactions, as most of them agreed that the mentally ill get much less attention from the government than they deserve. Some residents were against closing any hospitals including psychiatric hospitals.

The stigma which is attached to the mentally ill was synonymous with "mad" and carries with it the frightening connotation of being "out of control", unpredictable or violent. This identification of mental illness with madness was variously expressed as "lack of inhibition, erratic," "living in a world of their own" "unpredictable " "chain smokers" "walk naked" "very quiet" "begging" "asking for cigarettes" "prone to shoplifting" "unfriendly" "strange" "dirty". These perceptions were disturbing to the public , consequently they were alarmed at a possible increase in the number of former psychiatric patients in the neighbourhood. Knowledge of public perceptions of mental

illness is essential in understanding any resistance from the general public to community care policies.

Almost all of the local residents interviewed believed that hospital closure meant their increasing contact with psychiatric patients that could potentially lead to them being exposed to violence from patients.

The findings account for the growing concern of enlightened people with what community care actually means. The findings showed that local residents perceived community care as less reliance on specialist help for mentally ill people, less reliance on trained nurses and mental hospitals.

In order to counteract these fears, it is essential for the public to realize that former psychiatric patients would have supportive services in the community.

A. Reaction toward the decision to close psychiatric hospitals:

There was a need for more clarification of closure plans. Even though there had already been announcements in the local paper and by the local council about the opening of mental health facilities in the area, not everybody knew about it or were aware what it meant. Perhaps more discussion from The Grange staff, planning teams and the council or displays are required to ensure local residents are aware of what is going on, and to quell untrue or worrying rumours.

When those who participated in the survey were asked whether they had heard about community care only 43% indicated that they had, however they were unfamiliar with what community care meant. In the follow-up this figure dropped. For local residents community care meant voluntary help outside hospitals. Perhaps explaining that community care is providing individualized care in the community according to patients' needs could continue one of the strongest arguments for persuading the community to change their reactions.

B. Reaction towards community treatment:

Whereas a high proportion of local residents expressed a considerable reluctance to seek psychiatric hospital care for themselves, when it came to their relatives they preferred psychiatric hospital treatment for them. The rationale they gave regarding their relatives was that psychiatric hospital is the best place for treatment. Concerning themselves they indicated that they would only seek hospital treatment if their doctor referred them to it or there is nobody to look after them at home, or their condition is serious. This ambivalent response indicates that the respondents did not want to be stigmatized by seeking hospital treatment.

Meanwhile they were frightened of the responsibility of having to look after their relatives in the community. Similar results were obtained by Woodward (1951) and Maisel (1951) who showed that most preferred to consult their own family doctor before resorting to psychiatric help.

On the positive side, local residents thought that former psychiatric patients could live a normal life outside psychiatric hospitals. However, they indicated that they should live in sheltered accommodation. The results of this study revealed contradictory attitudes. Even though the local residents strongly disagreed with the government decision, they were less negative toward the proposal for developing the psychiatric services in the neighbourhood. This discrepancy could be attributed to the effect of the media, which tend to emphasis the negative aspects of community care. Several residents expressed an interest in playing a role in mental health facilities, such as visiting patients at home, taking them for outings, playing the piano. This highlights the importance of providing local residents with information about mental illness so that these residents could help their next door neighbour former psychiatric patients to adjust to the community.

Closure is taking place in the context of reorganization of the NHS and threats to its continuation which the public tends to feel strongly about. For all those concerned with people with mental illness, the closure of hospitals is now a major topic of interest. There is much speculation and little hard evidence. As part of the wider debate about community care, some sections of the media seize the opportunity to inform the public that closing hospitals leads to abandonment of patients in the community.

Headlines like these could scare the public. If hospital closure is to be successful, it is necessary to obtain a better understanding of the varieties and causes of popular perceptions of mental illness and to develop rational, preventative measures to prepare patients, staff and public before changing the nature of psychiatric care.

1.10.8 Community mental health services:

One could argue that the attitudes of residents next door to mental health facilities could influence patients' readjustment in the community and is therefore a crucial factor in the success of reintegration. Research is urgently required to widely investigate public attitudes and knowledge of mental illness, otherwise there will be a continuing danger of planning mental health services in complete ignorance of important factors involved.

The belief that the public will obstruct the opening of mental health facilities and the preference to sneak in psychiatric patients in various areas has been pervasive among professionals and has formed the framework of various mental health facilities. Surprisingly, a majority of the local residents expressed an interest in the opening of mental health facilities in their area and expressed the desire to offer help. The reasons given were: "each community should reflect facts of life, we cannot shut ourselves off from them" "local community could use the services" "lovely to have somebody to look after them".

This study provided insight into those with positive and neutral attitudes. It suggests that residents with positive or neutral attitudes could be recruited to help the

reintegration of former psychiatric patients, as well as identifying the contents of educational programmes required to effect a change in negative attitudes. Positive views could stem from the residents' experience with The Grange as they said that the clients at The Grange caused no troubles and were always accompanied by the staff, and described them as old and would not hurt anybody.

In contrast, Yankelovich (1989) found that facilities for mentally ill people were not well accepted in their neighbourhood, the affluent communities being most rejecting. Over 14% indicated that their community opposed the opening of mental health facilities in the area. Those who rejected such facilities tended to be male, well educated, professionals, married, home owners, living in large cities in the Midwest and less positive about mental illness. One third of those interviewed did not rank mental illness as a serious social problem. Age appeared to have little influence on their answers. Wahl and Lefkowits (1989) demonstrated that corrective information could counteract the effects of the stigma of mental illness.

Some residents indicated that their area is not suitable for former psychiatric patients because it is rough and they might get mugged, also that the road is very busy and lacking traffic signals which made it hazardous for them.

The public could best help by showing sympathy and understanding towards former psychiatric patients. However, some members of the local residents showed interest in actively participating in helping former psychiatric patients. For example local residents asked for practical help in how to approach them, and accept them in public places such as a local club.

The findings showed that the problem is many-sided. It would be unrealistic to use previous survey data to draw firm conclusions about the present situation. Perhaps more thought should be given by service planners to finding acceptable ways of making education of the public and contact with mental patients happen more systematically.

The presence of conflicting professional views about the approach to meeting patients' needs must be avoided. The international experience of deinstitutionalization shows that unless the development of community-based services is managed with considerable skill, the whole system can disintegrate.

Greenblatt and Glazier (1975) and Bachrach (1983) pointed out that community problems resulting from deinstitutionalization could be due to inadequate administrative planning. Administrative plans tend to give priority to administrative goals over patients' care plans. Difficulties of treating patients in the community as well as lack of participation of the clients, staff and the community in the planning process were ignored.

Aviram (1990) indicated that problems in community care for seriously mentally ill people were homelessness, poor service provision, lack of finance, monitoring patients, unemployment, bureaucracy in care delivery, burden on the patients' families

and conflict between mental health services. He pointed out that these problems were were related to organizational, financial and structural factors.

This study provides evidence that community care criteria for success should include: change in attitudes towards the concept of patient care, community acceptance of former psychiatric patients, education of the public about mental illness, and staff training for community care.

1.10.9 Public needs for preparation before former psychiatric patients move to their neighbourhood

Local residents indicated that they wanted a high standard of information about mental illness, such as practical skills in dealing with and acceptance of former psychiatric patients in the community, services available, prevalence of mental illness as well as the theoretical background about mental illness.

The majority expressed the need for preparation before moving patients into their neighbourhood, especially regarding medical knowledge of the illness, while a quarter needed reassurance regarding patients' background such as their aggressive behaviour. Some residents expressed the need for information about mental illness because it could be useful for them and helpful to protect their children. Others thought that preparation could lead to prejudice or protest against the facility.

The majority (80%) said they would like to be told about opening mental health facilities in their area. The reasons they gave were to know how to treat patients and to avoid clashes, while others wanted to keep their distance. One could argue that it is important to provide the opportunity for the public to discuss the behaviour of emotionally disturbed people to give them a greater understanding and calm their fears. Some residents could offer help and support to the patients. If the staff members of each facility concentrated on their immediate neighbourhood and focused their efforts on small groups they could probably involve individuals and help them to see how their contribution could aid the social integration of patients into the community.

Education

The results of the first and second interviews were strikingly similar and pointed to the conclusion that the mental health campaign could alter basic attitudes toward the mentally ill. It was interesting that the findings of this study resembled the conclusions reached about 30 years ago in London by Gatherer and Reid (1963). They considered the main problems in public education were: shortage of mental health personnel, designing the educational programme, and the danger of arousing anxieties and fear in the public.

2.THE QUANTITATIVE ANALYSIS OF PUBLIC ATTITUDES TOWARDS PEOPLE WITH MENTAL ILLNESS: REPERTORY GRID TECHNIQUE STUDY

2. MEASURING PUBLIC ATTITUDES TOWARDS PEOPLE WITH MENTAL ILLNESS: REPERTORY GRID TECHNIQUE STUDY

2.1 INTRODUCTION

One of the objectives of this study is to find out how the public perceive mental illness and mentally ill people. Do they classify them among other socially disadvantaged groups and if so where about do they place them? Is the public's perception related to preconceived ideas about mental illness? Furthermore, will local residents change their perceptions when former psychiatric patients move into their neighbourhood?. In this study it has been a major aim to establish a baseline of public conceptions of mental illness, and to measure any change in those perceptions over time. Repertory Grid Technique (RGT) was chosen as an appropriate tool to supplement the data from the less structured 'Public Perception of Chronic Conditions' questionnaire.

2.2 CONSTRUCT THEORY: ASSUMPTIONS UNDERLYING THE REPERTORY GRID

Kelly's theory of personal constructs is based on the assumption that each individual is basically a scientist. Individuals develop hypotheses which they actively test, modify or discard in order to survive. These processes affect how individuals see the world. Kelly maintained that individuals build up a network of hypotheses based on unique experience, which he called a 'construct system'. This system is developed or acquired through social experience. Some of this system is largely developed pre-verbally and some of it verbally transmitted, and not all of it is accessible to the individual in terms of self-consciously held concepts. Although in all cases aspects of this system are shared by others, it is unique to the individual to some degree. Kelly (1955) argued that we make sense out of our world by simultaneously noting likenesses and differences. Construct theory assumes that each person's constructs are organized into some personally useful hierarchy, some being more important to the subject than others. Accordingly, Kelly's (1955) fundamental postulate is that the ways a person behaves towards another will be determined by the ways he construes that person.

Kelly (1955) pointed out that perceptions of people and events are shaped by one's cognitive structure or one's own interpretive scheme as well as the actual characteristics of the people and events. The bi-polarity of meaning is central to the psychology of personal constructs. Kelly's philosophy of constructive alternativism states that all of our present interpretations of the universe are subject to revision and replacement.

It can be concluded that construct theory could be applied to identify a subject's feelings towards others in a quantifiable way, statistically analysing relationships between

the other people (elements) used by the subject. It is one of the major differences between construct theory and other theories.

2.3 REPERTORY GRID TECHNIQUE (RGT):

Kelly's (1955) RGT is designed to elicit a representative sample of constructs upon which the subject interprets and predicts the behaviour of significant people in her/his life, and to assess the way in which he relates these constructs to one another. All constructs must be within his range of convenience. This means that constructs always operate within a context and that there is a finite number of elements to which they can be applied by a given person.

Ryle (1975) described RGT as involving the subject in a developing semantic exercise, through which the subject defines and differentiates between the range of possible meanings of the terms he has used to make discriminations. Again, Bannister and Mair (1968) defined RG as 'any form of sorting task which allows for the assessment of relationships between constructs and which yields these primary data in matrix form'.

Osgood et al (1957) differentiated between Semantic Differential Technique (SDT) and RGT. They indicated that SDS is a standard list of dimensions supplied to all subjects, while RGT is a set of constructs which is elicited individually from each subject. Allport (1958) pointed out that RGT is idiographic, that is to say providing a picture of the individual's own personal view of the world. Constructs could be supplied or elicited. The main advantage of supplying constructs to subjects is that it permits a higher degree of standardization as a basis for nomothetic comparisons between different populations. Main (1964) attempted to clarify the nature of grid measures. He stated that RGT is directly and explicitly derived from certain central characteristics of personal construct theory. Reliability and validity of construct measures must take into account two main sets of assumptions underlying the use of the grid: first, theoretical assumptions concerning the nature of constructs as postulated by Kelly; second, methods of measurement.

Slater (1972) raised two issues concerning the reliability of RGT. First, whether or not subjects maintain consistency over time in the way in which they use the elements and constructs. Fransella (1970) referred to this issue as 'element consistency'. The second issue is whether specific patterns of relationships among constructs are consistent over time. This facet of reliability can be evaluated independently of the question of whether or not the same constructs are applied to the same elements on different occasions. Slater maintained that the correlation between any two constructs can remain approximately the same although the categories of particular figures on each construct is changed, provided that they have changed in terms of both constructs in a consistent way. Slater added that when a subject completes ratings of the same elements on two occasions, the data can then be treated as test-retest results for the same grid. If the

ratings are similar for a construct in one grid as for the one aligned with it in the second grid, test-retest reliability will be high. However, if the evaluation differs markedly, it will be low. Similarity in ratings on all constructs will provide reliability of the grid as a whole.

Fransella and Joyston-Bechal (1971) argued that the reasons for differentiating between these two forms of consistency in RGT data is that shifts in patterns of construct relationships are not always associated with changes in the categories of particular figures on these constructs, and conversely, people sometimes revise their specific impressions of their associates without altering the pattern of relationships between their constructs.

Sperlinger (1976) argued that if RGT identifies important aspects of the individual's constructs, then it would be expected that grids completed by the same individuals at different times would show some degree of stability and any change should be predictable. Sperlinger studied the stability of the RG measures by testing similar constructs on a group of subjects drawn from the registers of two clinics. The same individuals were retested after 8 months. The results showed considerable stability, especially in that the similarity of a subject's perceptions to others remained substantially unchanged.

The reliability of the SD has been established by applying test-retest reliability to ratings on 7-point scales (Osgood and Suci, 1969). The summations for means and variances were taken across items and scales. SD has been used to identify connotative differences among concepts on three major factors (evaluative, activity and potency) (Osgood et al, 1957).

Adams-Webber (1979) pointed out that research activity in personal construct theory has increased in spite of the issues of reliability and validity. He considered that this problem has been exacerbated by the wide spread use of grid tests.

It can be concluded that RGT is an instrument designed to elicit from individuals which characteristics (dimensions) they use to categorize a certain aspect of their environment, and how these dimensions relate one to another.

2.4 STUDIES USING REPERTORY GRID TECHNIQUE

This section will include studies which used (SD) and (RGT) to investigate generalizations about mentally ill people.

A number of authors have written that the process of labelling a deviant and the generalizations held about the type of deviants play a crucial role in determining the behaviour of the mentally ill. Husek and Bobren (1964) investigated the effects of labels and behaviour description in determining attitudes toward labelled behaviour. They carried out an experiment with 440 high school students divided into 2 groups. The first group rated labels such as "mentally ill" and "emotionally disturbed man", while the

second group rated descriptions of behaviour without labels on SD scales. They concluded that labels were more influential in determining attitude than case descriptions. Labels appeared more important in determining attitudes towards a paranoid person than towards a person with anxiety.

A variety of procedures have been used to investigate generalizations about mentally ill people. Goldstein and Blackman (1975) studied university students' generalizations about the following concepts: ideal person, Negroes, alcoholics, Americans, mentally ill, mentally retarded, physically disabled, criminals, yourself, and drug addicts. The students rated the concepts on 10 point scales. It was found that the concepts: drug addicts, criminals, and alcoholics were evaluated lower than ideal person, yourself and physically disabled, while Americans, mentally retarded, Negroes, and mentally ill were in the middle range. Mentally ill received a mixture of ratings: positive (as imaginative, sensitive and meditative), neutral (as quiet and impulsive) and negative (as unreliable, grasping, quick-tempered, evasive and suspicious). Mentally ill were rated similarly to the mentally retarded on sensitive, impulsive and quiet scales. Mentally retarded were described as honest, kind, faithful, reserved, ignorant, naive, and innovative.

Professionals' conceptions of mental illness have been considered important in the provision of care for mentally ill people, Mackey (1989) studied the personal concepts of the mentally ill among care giving groups using SD. Forty-eight mental health professionals, 69 police officers, 59 councillors and 43 welfare workers took part. The data revealed that although the four groups reported a high degree of contact with mentally ill people, there was a lack of consensus regarding definition and descriptions of mental illness. Police officers and public welfare social workers tended to associate mental illness with psychotic-like and socially deviant behaviour. Counsellors and professional tended not to answer the questions, describing highly variant behaviour or giving individualistic accounts of mental health problems. Likewise, Greenbaum and Wang (1965) studied the concept of mental retardation held by four groups (parents of mentally retarded children, professionals who are likely to deal with them, paraprofessionals and a group of business executives). The researchers compared mentally retarded with mentally ill people on 21 SD scales. The results showed that the concept of the mentally retarded person was mainly negative. The paraprofessionals and parent groups held more positive views than the professionals and employers groups but the general structure of the conceptions were the same for the four groups. All groups expressed positive views towards the mentally ill compared with the mentally retarded person.

Studies will now be reviewed that used RG to identify public perceptions of the mentally ill and changes in these perceptions. Consistency was found regarding public perception of the mentally ill. For example; Nunnally (1961) used SD with 250

members of the general public who rated concepts such as neurotic man, old man, insane man, on 7 point scales such as foolish-wise, unpredictable-predictable, and bad-good. Analysis of the ratings showed that negative attitudes were attached to people with mental health problems. The public rated mentally ill people as worthless, dirty, dangerous, cold, unpredictable, insincere. Further semantic analysis showed that the public viewed mental health professionals less favourably than doctors. Nurses were rated more favourably than psychiatrists on scales such as dangerous/safe. ineffective/effective. The results also showed that high school students considered mental institutions and treatment approaches less valuable and trustworthy than physical treatment. Nunnally suggested that the unpredictability of the mentally ill causes anxiety, consequently, the public feel uncomfortable and stigmatise them. Fracchia et al (1976) found that the constructs most strongly attributed to former mentally ill people elicited by 30 subjects were excitable, strange, tense, strong, uncertain, unsure, unpredictable, convincing, active, and mysterious. Nunnally (1961) reported the public stereotype of the mentally ill as dangerous, dirty, unpredictable and worthless. Fracchia et al (1976) suggested that one might be amused, bemused, confounded, perplexed, and puzzled by unpredictable behaviour. While to behaviour that is unpredictable but innocuous, one might react with anger and irritation, to behaviour that is unpredictable and dangerous one might respond with mistrust and fear, which Rosenhan (1973) has described as the major characteristics of public attitudes towards mentally ill people.

Green et al (1987) conducted a series of replications of the studies carried out by Olmsted and Ordway (1963), Olmsted and Durham (1967) and Walkey et al (1981). They used the same SD as was designed by Nunnally (1961). The SD consisted of the rating of eight elements about mental health on 12 seven point scales. The eight elements included: "mental patients", "insane people", and "ex-mental patients". These three ratings indicated attitudes towards mentally ill people. Ratings of the concepts "doctor" and "psychiatrist" were regarded as an indication of attitudes towards professional groups. The concepts "me", "most people", and "average man" were included as a frame of reference for the raters. Subjects of the study were university students matching those who participated in the earlier studies in New Zealand. Comparison between the replication findings and the earlier results showed that community attitudes towards the mentally ill had not changed over 22 years. The community was persistently negative towards the mentally ill but moderately favourable towards professionals. Former psychiatric patients were perceived as unpredictable, dangerous, tense, complicated, foolish, weak and slow. However, ex-psychiatric patients were viewed less negatively than insane people and mentally ill people. Psychiatrists were viewed less positively than doctors. The main aspects of the stereotype of a psychiatrist were: complicated and unpredictable.

Other studies investigated changes in public perceptions. Altrocchi and Elsdorfer (1961) carried out three experimental studies to investigate whether or not change in attitudes occurs as a result of increased information alone or through contact with the mentally ill and through intensive training and learning about psychotherapy with the mentally ill people. The samples studied consisted of 14 students (on a course for psychology) as an experimental group and 2 control groups of students in the Department of Economics and in the Department of Education. The instruments used were SD Technique, an information questionnaire and a Personality Description questionnaire. The results of the first study showed that increased information is not necessarily followed by changes in attitudes. The second and third studies were designed to investigate the effect of intensive training and personal contacts with the mentally ill person. The data of both these studies showed favourable change in the students' attitudes.

Orley and Leff (1972) measured changes in attitudes to different types of illnesses amongst educated Ugandan nurses, using an SD. The SD consisted of 11 diseases as elements and 8 constructs. The test was administered to three groups of students: 9 qualified psychiatric nurses, 17 nurses just beginning their psychiatric nursing course and 17 school leavers at the same educational level as the student nurses. The results showed that attitudes of Ganda nurses had changed during the course of their training. The trained staff had less tendency to categorize in terms of the traditional criteria of the Ganda population.

Similarly, Wilkinson (1982) used an SDS to compare the attitudes of student nurses to medical and psychiatric patients before and after they received their psychiatric training. The students were asked to rate case descriptions of 12 patients in terms of what they would expect if they were to nurse similar cases to the ones described. The results showed positive changes in the students' attitudes as a result of attending psychiatric nursing training.

Factors identified by SDS which generated community opposition to mental health facilities were examined by Dear et al (1977). They found that these factors were: invasion of privacy, and fear for personal safety. The researchers considered that the SDS is an appropriate tool to measure public perceptions of the health facilities in their neighbourhood.

2.5 RATIONALE OF USING REPERTORY GRID TECHNIQUE IN THIS STUDY

This study centres on the notion that recognition of the mentally ill is related to the extent to which the behaviour of the mentally ill person deviates from normality. It was suggested that community resistance stemmed from a perception of formarly institutionalized patients as exhibiting deviant behaviour. Such perception derived from several myths and fears. The rationale behind the use of RG in this study has been described by Jones et al (1984) who pointed out that contact between the public and a "marked" or an "unmarked" person will modify the perceptions the public has about the stigmatised condition, and about its impact on subsequent social interaction. They suggested that RGT is an appropriate tool in identifying personal perception.

It was decided to investigate how mental illness is construed by the lay public using RGT. It was postulated that the attitudes of the local residents would change after psychiatric patients moved into their neighbourhood. There would be less tendency for the population who come into contact with mentally ill neighbours to construe mental illness in traditional terms as disruptive, dangerous, permanent and easily identifiable from the sufferer's appearance.

It was decided to use the RG to study how the public perceive the mentally ill before any ex-psychiatric patients moved into their neighbourhood.

When faced with patients moving into their neighbourhood, the public would react towards them according to their construct system about mental illness. After six months the same method would be repeated with the same subjects under study to investigate whether or not coming into contact with mentally ill patients would affect the way they construe the mentally ill, and whether their attitudes towards the mentally ill would consequently change. An open-ended questionnaire was used to record any contacts or incidents that occurred between the subjects under study and the patients in their neighbourhood.

Public opinions and perceptions of mentally ill people in two British samples have been identified using open-ended interviews and are reported in part 3 of this thesis. It was found that the population sample classified mental illness on the basis of certain criteria. These include:

1. Social factors, such as poverty, unemployment, divorce, family problems and stress at work.
2. Abnormal physical appearance, such as looking excessively dirty, unusual facial expressions or wearing unsuitable clothes.
3. Socially disruptive behaviour, such as talking to oneself, communication difficulties, wandering about, confusion and aggressive behaviour towards others.

2.6 TECHNICAL HANDLING OF THE DAT

Fransella and Bannister (1977) suggested that various statistical measures could be applied to quantify the problem of reliability. They suggested measures, including:- T-test of group differences, correlation consistency measures, cluster analysis methods, significance of correlation methods and co-efficient of concordance. Beail (1984) investigated the extent to which a consensus grid represents the individual grid. He studied the relationships between the way a group of physically disabled adults construed themselves in relation to the way they have been construed by the public, using RG. The grid contained the two elements "how I see myself" and "how the public see the disabled" (stereotype). To test the hypothesis that physically handicapped people are unlikely to construe themselves in the same way as the public construe them. A sample of 30 physically handicapped adults completed a 6 x 12 RG using 5 point scales. Beail took the mean of each of the ratings across all 30 individual grids and created 'the consensus grid'. The results of the 'consensus grids' showed that the element (stereotype) was construed more negatively than the element (self). Pearson's correlation coefficient (r) was computed between the two elements on 12 constructs (C) of 'the consensus grid',the value of 'r' being > 0.8 [$p<0.01$]. Thus the correlation between the two elements (E) in the "consensus grid" appeared to show that they were construed similarly.

Then for each of 30 individual grids separately he calculated the same correlations. Analyses showed considerable variation for the relationships between the self and the stereotype. The value of r found ranged from -0.35 to +0.82 with a mean of +.31. A T-test was also applied to measure the variability in the subjects' responses for the two E on all of 12 C scales. T-tests, which take into account the variability in subjects' responses, produced a significant result for all RG scales at the 5% level, that is to say there was agreement among the raters that their view of themselves and their view of the public stereotype of handicapped people differed. Thus there was a major contradiction between the results of two different methods of analysis of the consensus grid.

Beail concluded that generalisation about certain groups made on the basis of the consensus can misrepresent the individual grid because the method does not take into account variations in response. Therefore he strongly recommended that investigators of group characteristics using RG should focus on the results provided by each individual grid, testing the mean correlations and the range of findings.

In the light of the recommendation of Beail (1984) and Fransella and Bannister (1977), it has been decided in this study to see Kendall's coefficient of concordance W, to estimate whether the consensus grids compiled in this study are representative of the various individual grids in Tottenham and Haringey that comprise them.

In order to verify the use of consensus grids in this study, SPSS/PC + was used to calculate Kendall's coefficient of concordance:W.

W has been described as a measure of inter-rater reliability, (eg. Siegel, 1957). W indicates the degree of divergence of variance from the maximum possible agreement (W = 1) to no agreement (W = 0). Statistics are calculated, correcting for ties.

W in this study will be an index of whether or not there is an agreement among the subjects under study in rating elements on the constructs in both areas, Tottenham and Haringey, on two occasions.

While Spearman and Pearson correlation coefficients represent the degree of agreement between variables, W estimates the degree of association of ratings on complete agreement. Hays (1973) points out that W cannot be negative. The value of the concordance coefficient is hard to interpret directly in terms of the average value of rs over all possible pairs of rank orders.

In this study the grids used were nomothetic - that is to say the same grid was given to all the subjects in the study. Therefore, it has been decided to look at the quality of the grid information. This study will answer the following questions:

Is reliability stable over time in the control group? Is there inter-rater consensus within the constructs? Is there some internal reliability in the ratings of the elements across the constructs? Can summary measures be produced on the basis of this internal reliability? What do individual grids show? What do consensus grids show?

2.7 Criticism of Literature Review

The literature review revealed a paucity of studies using R.G.T. with members of the public or measuring change in attitudes as a result of information about or contact with mentally ill people. Studies on specific groups such as university students, care givers and parents of people with learning difficulties have been used to generalise about attitudes towards the mentally ill (Olmstead & Ordway, 1963; Husek & Bobren, 1964 and Walkey et al, 1981)

The first study that used SDT with members of the general public was that by Nunnally (1961); the same grid was used in a number of replication studies. However, no study has used R.G. technique to assess change in public attitudes to the mentally ill over time. The issue of consistency over time has been tackled by a number of researchers (Osgood and Suci, 1969; Fransella and Joyston-Bechal,1971; Slater, 1972; Sperlinger, 1976) who have concluded that this is a satisfactory aspect of R.G. technique.

2.8 REPERTORY GRID TECHNIQUE METHODOLOGY

It was expected that psychiatric patients would show a pattern of social interaction within their neighbourhood which differs from that of the local residents in terms of general appearance, and initiation of and participation in conversation. As a result of this pattern of behaviour it was thought that local residents would behave differently toward ex-psychiatric patients living in their neighbourhood than they do towards other residents in the area.

The RG Technique was designed to test the following null-hypotheses:

1. There is no difference between the study group and the control group in their attitudes towards the mentally ill.
2. The behaviour of psychiatric patients has no effect on the attitude of the local residents.
3. There are no differences in the attitudes of the two groups towards mentally ill people and other socially deviant groups.
4. There is no difference in the rank orders of degree of negative attitudes towards mentally ill people and non-mentally ill people between both groups.
5. There are no constructs that are more specifically associated with the mentally ill than others.
6. There are no elements that are more specifically distant from the mentally ill than others.

A. Exploratory Objectives:

7. which other elements are most like the 'mentally ill'?
8. how 'simple' is the grid?

B. Operational Definition

- study group: group of residents living in the same street and within 100 yards of the mental health facility in which long-stay psychiatric patients moved to live.
- control group: group of residents living in an area where no known psychiatric patients are moving in: a street parallel to that of the study group in which the psychiatric patients are most unlikely to be seen by these residents; minimal contact with psychiatric patients is expected.
- psychiatric patients: long-stay chronic non-demented psychiatric patients discharged from local state hospitals.

C. The Study Sample

In order to investigate changes in public attitudes resulting from their contact with psychiatric patients, it was decided to compare attitudes of 8 of the local residents who live opposite community mental health facilities before patients moved and 6 months after patients moved into their neighbourhood. Any changes in attitudes detected would

be compared with those of 10 residents from the control group it should be ted that, no facilities for the mentally ill had previously existed in the control area.

Each person was first interviewed using the open questionnaire, then the same descriptions of the mentally ill elicited during the interview were used in the RG to ensure that the terms were familiar. The subjects were first asked whether or not they knew somebody who exemplified the elements presented; then they were asked to describe that person, and to rate him/her on a 5 point scale. When the subjects finished their descriptions, the investigator began to complete the RG by giving various descriptions for the same person and asking the subject to rate them.

The local residents were told the purpose of the study: they were informed that the investigator was interested in studying what they think/expect of some people's behaviour. What resulted from these interviews was a mass of data containing personal perceptions, beliefs, experiences, and attitudes which illustrated additional beliefs about the mentally ill.

D. Tools of the Study

In this study an RGT format was adopted to investigate the changes in local residents' attitudes upon contact with former psychiatric patients in their neighbourhood. Another aim was to determine whether or not the public differentiate between the person himself and the illness. The evaluative components will be seen as distinguishing between "normal" and "deviant" behaviour. Previous use of SDS and RGT using a 5-point rating scale on each construct, has shown it to be a practical instrument even with a lay population.

Show (1967) stated that it is important to attempt to quantify attitudes, and indicated that the SD and RG provide an accurate measurement of the individual's perception of the elements.

Bannister and Fransella (1971) pointed out that the great advantage of the RG is that data from a single individual can be subjected to various statistical tests, the results of which can be generalised to subjects with similar social characteristics.

A full RG contains three components:

1. Elements are the objects of people's thoughts (Smith 1980), which define the material upon which the grid is focused. Easterby-Smith (1981) indicated that elements must be specific, homogeneous (drawn from the same category) and provide representative coverage of the reactions to be investigated.
2. Constructs are the ways that the interviewee groups the elements and differentiates between them.
3. Assessment scales which can show how each element is being assessed on each construct. Slater (1972) stated that a grid must contain terms of both the elements and constructs referring to a common topic, so that all elements can be evaluated on all the

constructs. Both may be supplied or elicited. The evaluation may be on any grading scale or may be made by ranking. There is no universal standardized procedure.

E. Development of the Grid

A. Pilot study

It was decided to try eliciting a grid from a volunteer from the public to find out the possibility of using this method with the study groups. The triading method was tested using "laddering" to generate the constructs, and providing role descriptions to generate the elements. The pilot study took 3 hours without completing the grid. It was also found that the volunteers had difficulty in thinking of new constructs to describe hypothetical individuals. Consequently it was decided to supply the elements as well as the constructs as a quicker way to formulate the grid.

Generating the Constructs.

The particular choice of construct was crucial since irrelevant or inappropriate factors might eventually emerge from the analysis. In order to supply constructs that are known to be representative of the ones that the subjects under study would have produced spontaneously, and would have adequately understood, 100 members of the public in three areas of London [Muswell Hill, Kentish Town and Hampstead] were asked two questions. The respondents were passers-by in the street. The questions were:

1. Can you recognise somebody who is mentally ill?
2. If yes, how can you recognise somebody who is mentally ill?

In answer to the first question 97 out of 100 said 'Yes'. Of these 30% confused psychiatric patients with alcoholics, or mentally handicapped people. It was found that all the adjectives used to describe mentally ill people given by the public were negative. The adjectives were amalgamated into 5 descriptions of the mentally ill person. The RG was formulated by supplying positive descriptions to supplement the negative adjectives given by the public. The adjectives provided by the public were assigned the highest score on a 5-point scale, [1] while the opposite adjectives provided by the investigator were assigned the lowest score, [5].

Two pilot studies were conducted on five subjects from the same area. A computer analysis was carried out using the Ingrid program by Dr.P.Slater to identify the important constructs.

The constructs curable/incurable and physical uncoordination/physical coordination were excluded because they were inapplicable to most of the elements. Also, the construct dangerous/safe was broken down into 2 constructs, dangerous to himself/safe, dangerous to others/safe.

The final construct system consisted of the following 13 pairs.

1. Constructs concerned with personal appearance: dirty/clean, looks different/looks ordinary.

2. Constructs concerned with socially disruptive behaviour: dangerous to himself/safe, dangerous to others/safe, rough/polite, noisy/calm, difficult to talk to/easy to talk to, unfriendly/friendly, changeable/stable.
3. Constructs concerned with mood and activity: depressed/cheerful, angry/calm, aimless/purposeful.

Generating the elements

The constructs were used to rate the following elements in addition to the mentally ill: vagrants, alcoholics, the mentally handicapped, the unemployed, old age pensioners, students, and people who are healthy most of the time. The rationale for using these elements was:

a. Alcoholics and mentally handicapped people were included because: they were mentioned by the public either to describe the mentally ill or the public were confusing mentally ill people with them. Therefore, it was decided to include them in the RG to study differences in attitudes towards the mentally ill between the subjects who were expressing this confusion and those who were not. An additional reason for including the mentally handicapped was that a hostel for mentally handicapped people had opened in the same area, and public attitudes might have been expected to change the most towards this group of people.

b. The unemployed and old age pensioners were chosen because they were low income, relatively low status and considered as socially different, features they share with psychiatric patients. The unemployed and senior citizens are two categories of people who form a large proportion of the group under study. Interestingly, Wilson [1984] used the same two elements in her study.

c. The elements (people who are healthy most of the time/students/the people whom you like most) were chosen to mask the investigator's special interest in mentally ill people. They were intended to provide a baseline. These three elements were also included to help the investigator determine how the general public distinguish between people they like or think are healthy and can tolerate, and mentally ill people.

F. Procedures

A grid consisted of the same elements and constructs used by the same informant who followed the same procedures on two occasions. Questions and responses which proved to be reliable in the pilot study were used in the study. Random groups of the general public were found to be extremely consistent in their perceptions of elements, even when these were chosen by themselves. Nine elements and 13 constructs were chosen. Four consensus grids were prepared by calculating the mean ranking for each cell in all 36 grids taken together. The rating measures consisted of a booklet of 10 pages with 13 items. On the first page were the introduction and explanation about the procedures to be followed. The description of the elements was arranged as a 5-point

bipolar scale, ranging from the elicited construct to the one supplied. To avoid monotony of the answers and a halo effect the directionality of the elements was alternated for each successive construct scale.

The elements were listed and numbered in the following pages, one page being devoted to each element. The subject was required to make an overall judgement about all the constructs. Each element was given a score of 1 to 5 on each construct, the mid point (neutral position) indicating that the construct was inapplicable to the element concerned.

The interview

Letters were sent to the local residents. The interview started with an introduction by the interviewer about the purpose of the interview. An open-ended interview was administered first to get to know the interviewee and as a way of establishing rapport with him. Then he was asked to give his/her opinion and perception of the mentally ill. The answers were recorded. At the beginning of the application of RGT, subjects were asked if they knew someone from each of the nine categories of people. The name of the person mentioned was referred to during the administration of the grid. If they did not know anyone, the investigator asked if they could describe what someone in that category might behave like.

The use of open-ended interviews in combination with the RGT was expected to provide insight into the complex attitudes of the local residents towards the mentally ill and provide an opportunity to study the individual's experience with the mentally ill and feelings about and reactions to having mental patients in the neighbourhood.

The terms used by the interviewee when questioned about his concept of mentally ill people were used in the RG. The RG was then administered to the subject using the same terms to describe the mentally ill. In all, most of the people used the same adjectives which were provided in the RG.

However, the supplied constructs were given after constructs had been elicited to avoid influencing the type of adjectives that the subject himself would choose e.g.'wanders about' instead of 'aimless' 'aggressive' instead of 'dangerous' to others.

2.9 RESULTS OF THE REPERTORY GRID STUDY

The aim of this study is to measure whether or not there are changes in the attitudes of the local residents in the Tottenham area (Study Group) after the patients had moved into their neighbourhood. A comparison was made of two sets of Repertory Grids (RG) for Tottenham group (Study Group), and Haringey group (Control Group) on two occasions:

Occasion one:

Before patients had moved into the Tottenham area.

Occasion two:

When the patients had been living in the Tottenham area for 6 months.

Data analysis aimed at:

a. Finding out whether there are significant variations in the subjects' perceptions of both the elements (E) and the constructs (C) in both Tottenham and Haringey areas on the first occasion.

b. Measuring changes in perceptions of the elements and constructs in Tottenham in comparison with Haringey on occasion two.
Using Two-Way analysis of variance repeated measure on the two groups to test for an interaction effect of group by time.

Methods of Data Analyses

A series of preparatory analyses and familiar packages were conducted using SPSS/PC + V2.0 and SAS/PC V.6.0. They were:

1. Test-retest reliability or temporal stability, i.e. how much change in the Tottenham group.
2. Inter-rater reliability or inter-rater concordance.
3. Internal reliability.
4. Test-retest correlation of summed ratings.
5. Inter-rater agreement on summed ratings.

Further analyses were conducted using Fortran programme "GAP" (Grid Analysis Package) written by the late Dr. Patrick Slater. These programmes include:

1. The Ingrid program: based on the principal component analysis of individual grid was used to measure changes in the individual grids.
2. The Series program was used to compile the Consensus grid to compare two grids and extracts a grid of differential changes; then analyse it to find dimensions where changes have occurred.
3. The Delta program was used to carry out various analyses for the consensus grids for both areas on two occasions to find communality in the two consensus grids, to demonstrate linkages and variations between them.

PART ONE

Reliability of the Consensus Grids:

Reliability in this study means testing to what extent the individual grid is represented in the consensus grid. There must be some inter-subject reliability to form the consensus grid. Fransella (1975) and Fransella and Bannister (1977) pointed out that one of the advantages of using RG is that the data from several individual can be averaged and produces a consensus grid which can then be analysed in the same way as the individual grid. However, the use of consensus grids has raised the problem of reliability and how much the individual grid is represented in the consensus grid, (Tagg 1977). Beail (1984) argued that the consensus score does not represent the construing of an individual grid as there is no account taken of the variance within the matrix.

Very little literature was found in the area of retesting under identical conditions with identical elements and constructs. The concept of reliability was used by various investigators to measure consistency in perceptions of constructs and elements over time. For example, Bannister and Fransella (1966) described the systematic relationships between constructs and their consistent relationships with different elements. Emerson (1982) used test-retest reliability to investigate elements and construct stability in RG over a seven month period.

In the following part aspects of reliability investigated in this study were:

1. Test-retest reliability of the grids

The objective of this section of the analyses is to measure both temporal stability and consistency of responses to the constructs used in the grids over a period of 6 months. (i.e. to detect the degree of changes in the stability of the constructs). The number of variables inspected was 234 (13 constructs and 18 subjects). Test-retest correlations reveal that nine variables are missing because a construct recorded no variation at all on at least one occasion. To summarise the strength of linear association between the constructs, there are 33 negative correlations and 192 positive correlations, four of the positive correlations are perfect.

According to the hypotheses of the present study, public perceptions will change when patients move to the community of the study group (Tottenham). One would expect the perceptions of the control group (Haringey) to be relatively stable. For the purpose of this study, the correlations that represent these six month test-retest correlations are those in the Haringey group. 130 correlations (13 constructs and 10 subjects) were inspected. The mean of the remaining correlations was .52 with the summary statistics.

Quartiles is used to describe the range of measures of variations of the group as a whole to avoid calculations based on extreme value.

Table 2.1 **Quartile (n=127)**

75% Q3	0.76
50% Med	0.60
25% Q1	0.34
Range	1.512348
Q3-Q1	0.412179
Mode	0.5

These are the quartiles describing the 127 Test-retest correlations. (127=13 constructs by 10 people, three of which were missing presumably because they recorded no variations on one or both occasions). From Table 2.1 it can be concluded that, 25% of the constructs are above .76 which indicates high stability; 50% or above .60 which indicates a moderately stable basis to the ratings.

2. Inter-rater reliability

The Kendall Coefficient of Concordance (W) was used to measure inter-rater reliability of ranking of the elements across each construct. W has been calculated on each construct within each location (Tottenham and Haringey) on each occasion, and on each occasion with the two locations' pooled data.

In order to find out whether or not there is a divergence of the actual agreement in the data from the (perfect) maximum possible agreement among the subjects, the value of the variables was ranked from 1 to 5 for each element and the mean rank was calculated for each variable over all elements. Statistics are calculated, correcting for ties. W ranges between 0: no agreement and 1: complete agreement.

In Tottenham Group- occasion 1:

The results showed that there was agreement among 8 raters on 11 out of 13 constructs greatest agreement (P=<0.001) was shown on C 1, 2, 5, 12 (Dangerous to himself/safe), (Dangerous to others/safe), (Dirty/clean), (Looks different/Looks ordinary).

Haringey Group- occasion 1:

The group showed statistically significant agreement on all constructs.

Tottenham Group- occasion 2:

The group maintained the disagreement on C 7 as on the first occasion. They also showed disagreement on C 3,10 and 11 (Angry/calm) (Difficult to talk to/easy to talk to) (changeable/stable).

Haringey Group - occasion 2:

Similar to Tottenham group on occasion 1 and 2, the group showed disagreement on C 6 (rough/polite) C 7 (Noisy/quiet). Conversely, the greatest agreement was shown on the C 1,11,12 (dangerous to himself/safe) (changeable/stable) (looks different/looks ordinary).

Relationships between the elements and constructs: Mean Ratings.

Tottenham Group- occasion 1:

Person with alcohol problem, vagrant, mentally handicapped and mentally ill received lowest ranking on C, (Dangerous to himself/safe) respectively. C, (Dangerous to himself/safe) showed highest ratings on E 4, 2, 9, 8 Healthy person, Student, Most wanted neighbour and Old age pensioner respectively.

A mentally ill person showed lowest ranking among the rest of E on C 13, 3, 2, 11, 9 (Unfriendly/friendly), (Angry/calm), (Dangerous to others/safe), Changeable/stable), and (Depressed/cheerful) respectively.

Haringey Group- occasion 1

Similar to Tottenham group, occasion 1, E 4, 9, 8, 2. Most wanted neighbour - healthy person, student and old age pensioner received the highest ranking among all the C. While E 5, 7, 6, mentally ill person, person with alcohol problem and mentally handicapped person received the lowest ranking among all the elements.

Mentally ill person received the lowest ranking out of the other E on C 9, 10 (Depressed/cheerful), (Difficult to talk to/easy to talk to).

Tottenham Group- occasion 2:

Elements 4, 9, 2, 8, healthy person, most wanted neighbour, student and old age pensioner received the highest ranking. While E 1, 6, 7, 5 - vagrant, mentally handicapped person, person with an alcohol problem and mentally ill person received the lowest ratings.

Haringey Group- occasion 2:

Similar to the 1st occasion, Most wanted neighbour, healthy person, student, old age pensioner, have received the highest ratings, while mentally ill person, mentally handicapped person, person with an alcohol problem, and a vagrant have received the lowest ratings. Mentally ill person, mentally handicapped person and person with an alcohol problem received similar lowest ratings on C 1 and 8 (Dangerous to himself/safe), (Not like myself/like myself).

Tottenham Group- pooled data :

Healthy person, most wanted neighbour, student and old age pensioner have received the highest ratings, while person with alcohol problems, mentally ill person, mentally retarded and a vagrant person have received the lowest ratings.

Haringey Group- pooled data:

Similar to Tottenham group, Most wanted neighbour, healthy person, student, old age pensioner and unemployed received highest ratings on most of C. While Person with an alcohol problem, vagrant, mentally ill person and mentally handicapped person have received the lowest ratings.

It can be concluded that there has been a consistent agreement between Tottenham and Haringey groups on both occasions about high ranking regarding the following elements: healthy person, most wanted neighbour, student and old age pensioner. At the same time, there has been consistent agreement about low ranking of the following Elements: person with alcohol problems, mentally ill person, mentally handicapped person, and the vagrant person.

3. Internal Reliability

Just as the assessment of the inter-rater consistency and test-retest stability of ratings of elements on constructs, so too can the inter-construct consistency of the ratings of the elements by raters can be assessed. Cronbach's coefficient alpha was applied to provide a direct analogy of the traditional measurement of internal consistency or internal reliability.

Table 2.2 Ratings of all 18 subjects (study and control groups) on occasion 1 (Cronbach's coefficient alpha)

Element	Alpha	Sd.element alpha
E1 A vagrant	.82	.82
E2 A student	.91	.92
E3 An unemployed person	.82	.85
E4 A healthy person	.57	.
E5 A person with mental illness	.88	.88
E6 A person with mental handicapped	.92	.92
E7 A person with an alcohol problem	.88	.88
E8 An old aged pensioner	.76	.77
E9 Person you would most like as neighbour	.87	.

The absence of a standardised element alpha should indicate that the element has recorded no variation between raters on at least one construct, e.g. constructs 1 and 6 (dangerous to self/safe) (rough/polite) has element 4 (a healthy person) rated as 5 by all 18 raters on the first occasion - leading to the missing standardised coefficient in the table above. Again construct 1 (dangerous to self/safe) has element 9 (person you like most as a neighbour) rated as 5 by all 18 raters.

Table 2.3 Ratings of all the 18 subjects (study and control groups) on occasion 2:

Element		Alpha	Std. element alpha
E1	A vagrant	.82	.81
E2	A student	.76	.80
E3	An unemployed person	.83	.84
E4	A healthy person	.72	.
E5	A person with mental illness	.86	.86
E6	A person with mental handicapped	.88	.88
E7	A person with an alcohol problem	.84	.84
E8	An old aged pensioner	.87	.88
E9	Person you would most like as neighbour	.80	.82

Low Alpha was found on E4 (a healthy person) on both occasion. The values on each occasion are not uniformly high but are generally acceptable. This suggests one simplification of the data matrix is to sum all the ratings for each element on all constructs for each rater on each occasion and analyse these 9 variables (one for each element) using univariate 2-way Anovas. Clearly the element of interest is E5, (A mentally ill person). There was an insufficient number of subjects in the sample to apply Multivariate Anovas.

For element 5 (mentally ill person) the results were as follows:

Univariate main effect of group on occasion 1: F (1,16) = 2.44, P=0.14

Univariate main effect of group on occasion 2: F (1,16) = 3.07, P=0.10.

Manova tests of repeated measure main effect: F (1,16) = 0.34, P=0.57 (by all four main Manova methods)*

Manova tests of repeated measure interaction: F (1,16) = 0.006, P=0.94

Manova main effect of group: F (1,16) = 4.72 P=0.0451.

This suggests that the two groups, though not significantly different on univariate testing, the results showed a trend towards significance on the two way repeated measures analysis. This showed no evidence of any effect of group on time.

* Wilks' Lambda, Pillai's Trace, Hotelling-Lawley Trace, Roy's Maximum Root. Spss/pc+ v-2.0 Adv.statistics p.B-126

4. Test-retest Correlations of Summed Ratings

For summing the construct ratings for each rating, the test-retest correlation for the summed data across the 9 elements was computed. The Spearman values for each area on the two occasions was as follows:-

Table 2.4 Tottenham group (occasion 1 and 2) (Spearman Coefficient)

Rater 1	.14
Rater 2	.03
Rater 3	.73
Rater 4	.32
Rater 5	.31
Rater 6	.82
Rater 7	.25
Rater 8	.78
Mean .42 (n=8)	
S.D. .29	

Table 2.5 Haringey group (occasion 1 and 2) (Spearman Coefficient)

Rater 1	.78
Rater 2	.93
Rater 3	.68
Rater 4	.62
Rater 5	.31
Rater 6	.82
Rater 7	.39
Rater 8	.63
Rater 9	.71
Rater 10	.95
Mean .73 (n=10)	
S.D. .16	
Grand Mean .595 (n=18)	

From the above tables, the inter-individual range in the correlations is very large. The mean for Haringey group (.73) was significantly greater than the mean for Tottenham group (.42) (T=2.12. d.f.=16, P<.05).

5. Inter-rater Agreement on Summed Ratings

Kendall's Coeffecient of concordance was carried out on the summed element ratings on both groups on both occasions. The results showed highly significant agreements between the raters. This results showed that the constructs were systematically related to the elements and their interrelationship was maintained.

Table 2.6 Summed Elements Ratings - Inter-Rater Concordance

Study Group	W	P
Occasion 1	.6126	0.01
Occasion 2	.5334	0.01
Control Group	**W**	**P**
Occasion 1	.6735	0.01
Occasion 2	.6979	0.01

Table 2.7 Summary of the P values for the elements

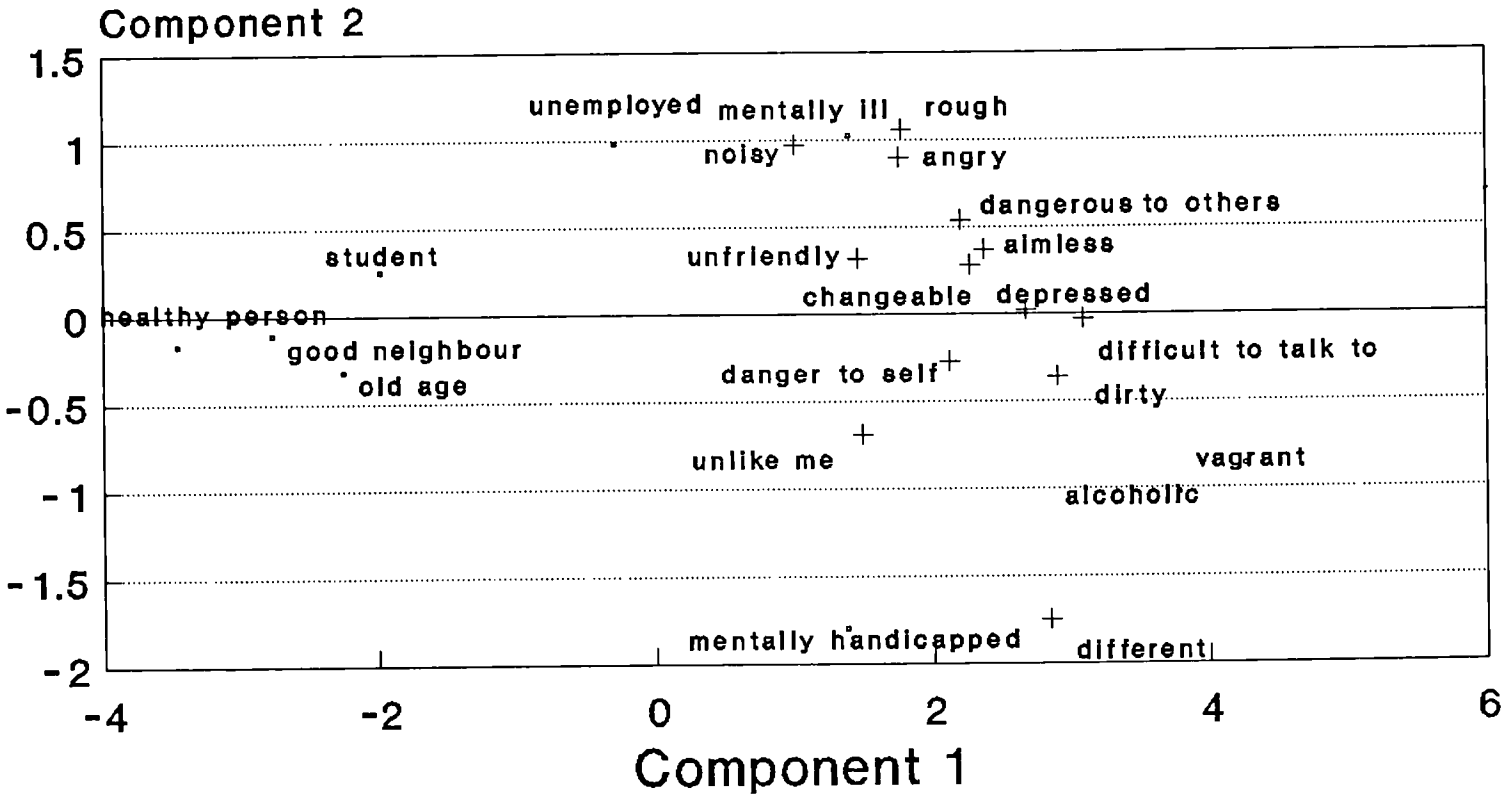
Elements	Occasion 1 group diff.	Occasion 2 group diff.	Occasion diff.	Interaction between occasion and group	Group diff.
E1 A vagrant	.08	.96	.15	.04	.35
E2 A student	.74	.11	.16	.12	.66
E3 An unemployed person	.49	.005	.96	.13	.02
E4 A healthy person	.61	.10	.40	.21	.17
E5 A mentally ill person	.14	.10	.57	.94	.05
E6 A mentally handicapped person	.74	.36	.04	.27	.75
E7 A person with alcohol problem	81	.70	.19	.51	.94
E8 An old aged pensioner	.82	.67	.77	.77	.70
E9 A most wanted neighbour	.61	.048	.47	.35	.2

These results show no significant group differences in the rating of the elements (summed across all constructs) on the first occasion. On the second occasion, significant difference was expressed in relation to the unemployed person at 5% level. There were statistically significant differences ($p<.04$) by occasion on element 6 (a person with mental handicap). There was no significant interaction between occasion and locality on any element (Table 2.7).

To conclude:

There is strong justification that the grid method in the form it has been implemented in this study shows the presence of a reasonable inter and individual commonality in the ranking of the elements on each construct. There is strong evidence that the choice of the constructs strongly suggests that most of the constructs might be subordinate to one superordinate evaluative construct upon which each element was rated. There is also evidence in the control group of quite considerable stability over six months in many of the ratings. These two findings suggest that a consensus analysis of the grids will not be too misleading.

Consensus Grid of Eperimental Group occasion one

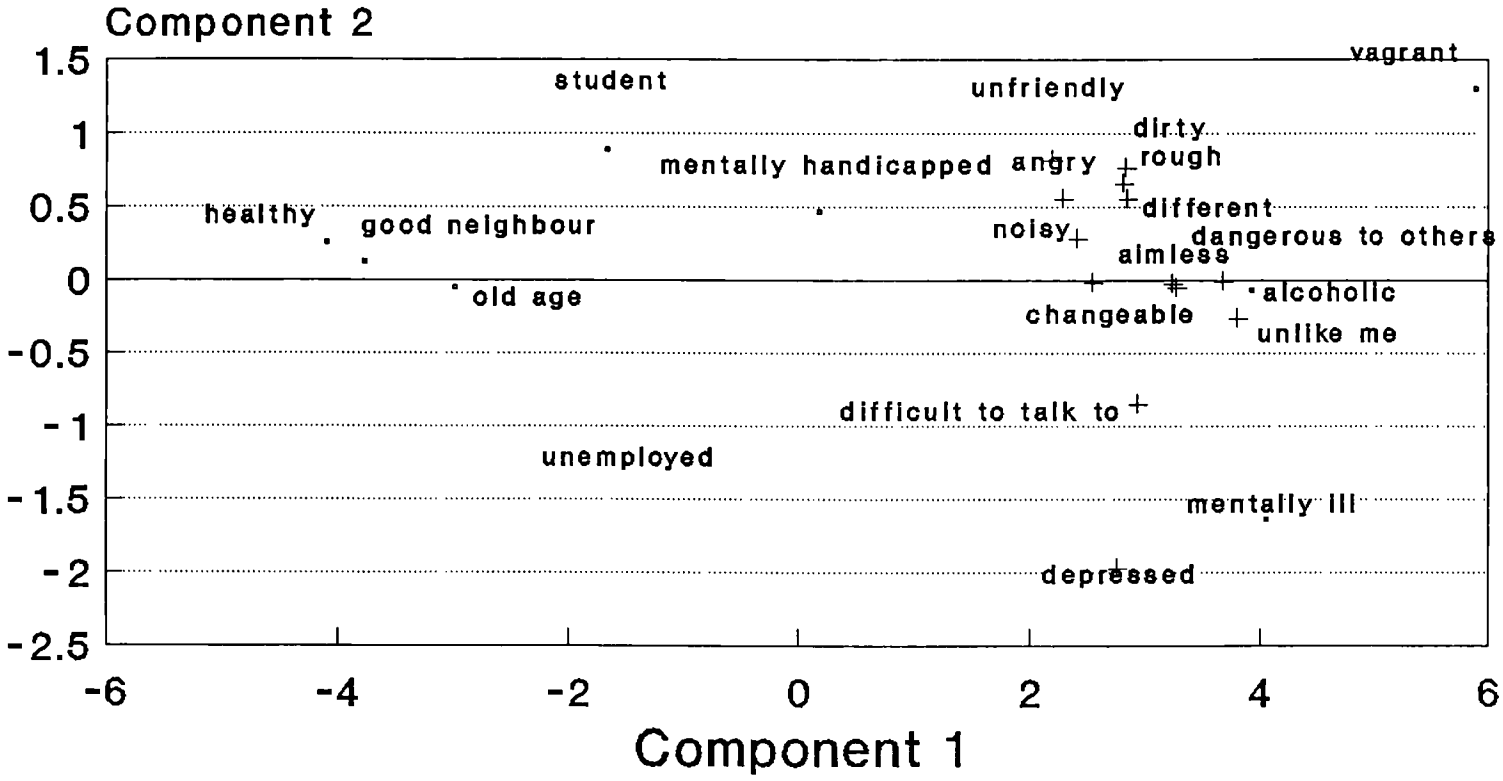


· Elements + Constructs

Figure 2.1

Consensus grid of control group

occasion one



Figur 2.2

Consensus grid of Experimental Group occasion two

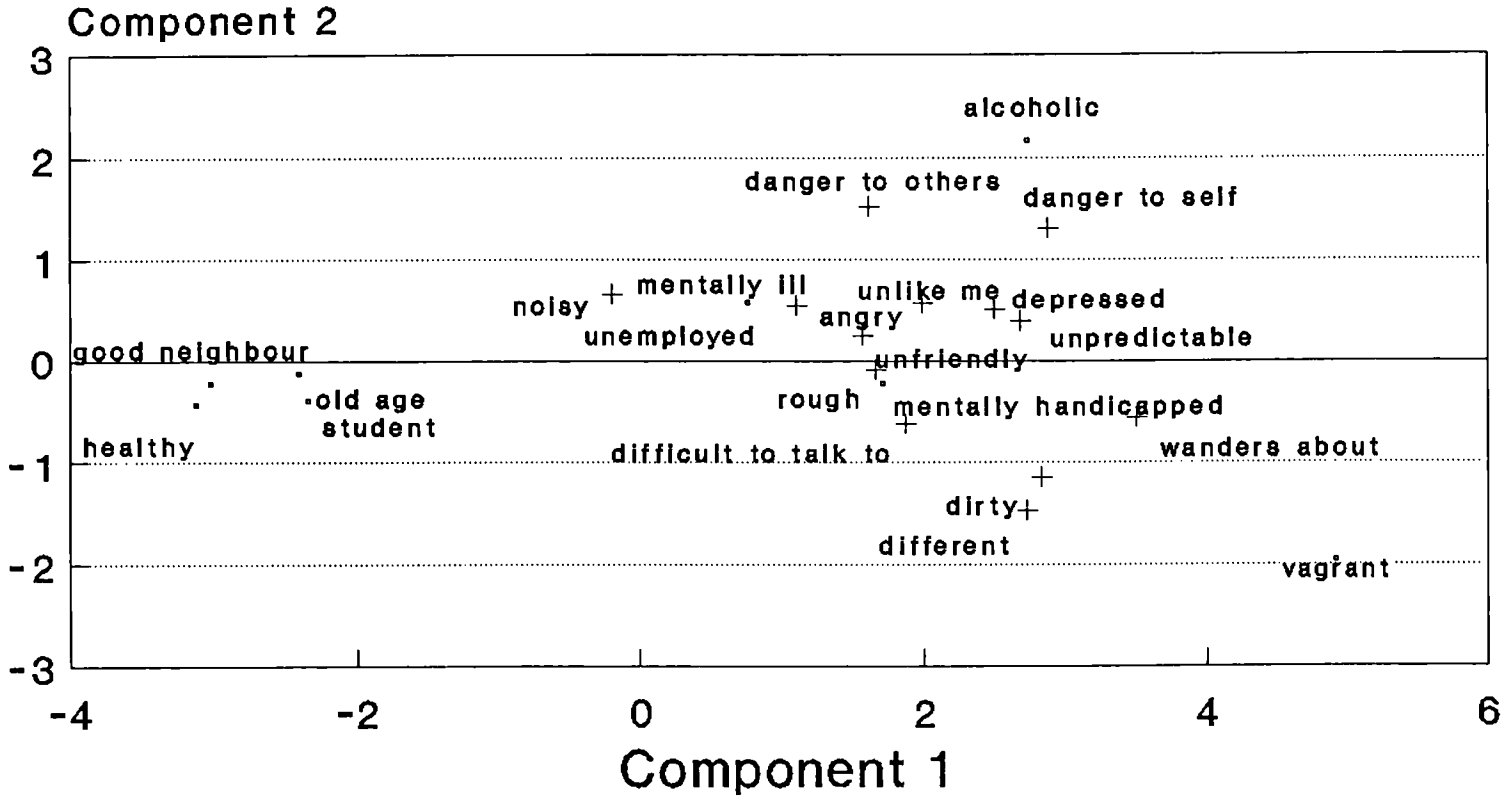


Figure 2.3

Consensus grid of control group
occasion two

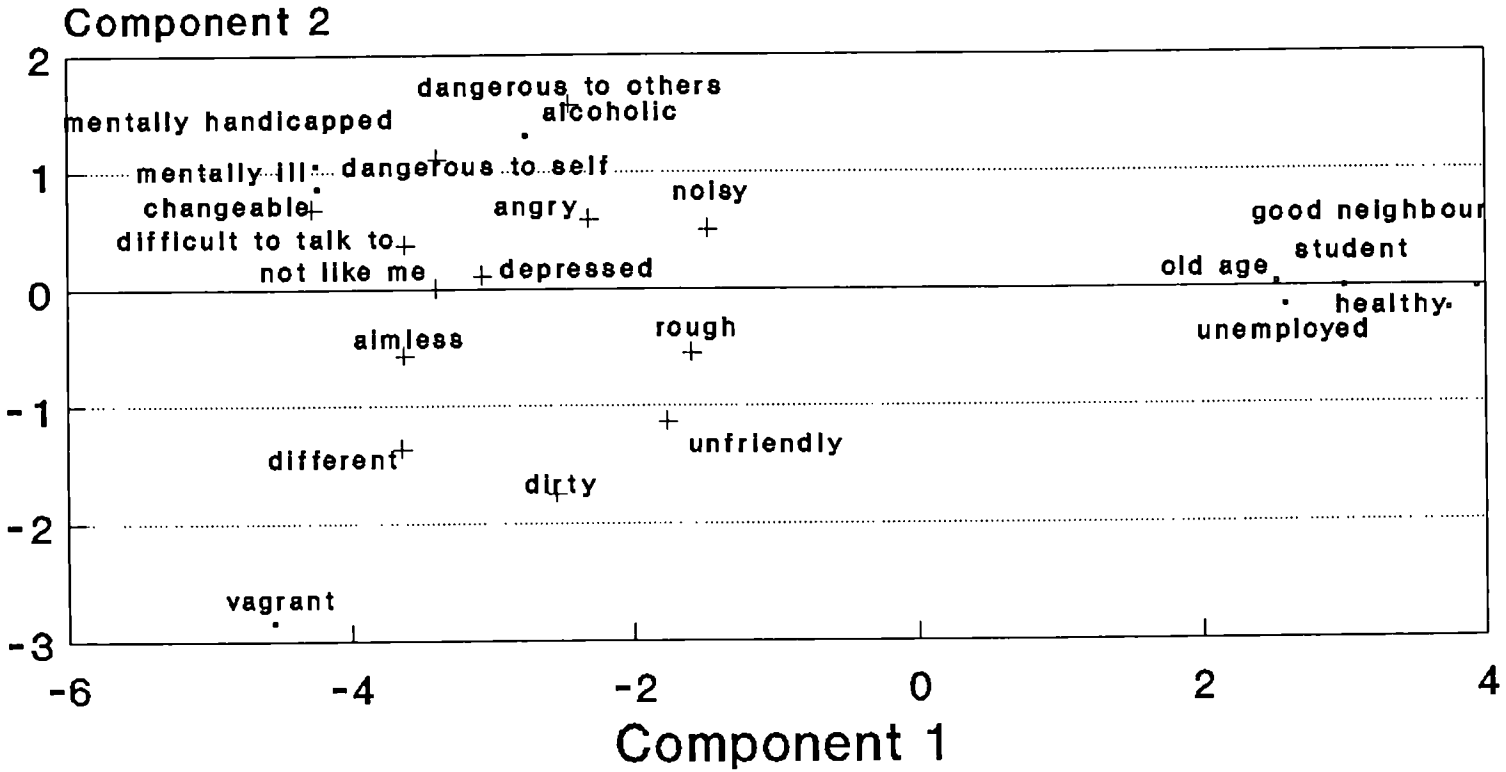


Figure 2.4

PART TWO
INGRID PROGRAMME'S RESULTS
CONSENSUS GRIDS

In the following section the results of the Principal Components Analysis will be presented as well as the possible reasons underlying changes that occurred.

Study Group- occasion 1 (see figure 2.1)

This grid has high intercorrelations between constructs. The first component in the principal components analysis accounts for 76% of the variance, which is exceedingly high. The dimension consists of two poles: the first will be termed the bad/mad pole (consisting of the constructs: dirty, difficult to talk to, depressed, a danger to himself, a danger to others, unfriendly, changeable, aimless) while the second pole will be termed the good/sane pole (consisting of: clean, easy to talk to, safe, cheerful, friendly, stable, safe to others and purposeful). A vagrant, an alcoholic and a mentally ill person (less marked) lie at the pole mad/bad, while a healthy person, a person you like most and an old age pensioner lie at the good/sane pole.

The second dimension has no constructs closely associated with it but is formed of the element: a student at one pole and the element: the mentally handicapped at the other, and would therefore appear to be mainly about intelligence.

Study Group occasion 2 (see figure 2.2)

There was a slight reduction in the tightness of the grid, with the first component accounting for 69% of the variance. The data also have a two dimensional structure. The first component is formed of much the same values as before with a bad/mad pole and a good/sane pole.

A vagrant and an alcoholic rate worst and are located at the bad/mad pole. A mentally ill person was more neutral on this component. A healthy person, a liked person and a student are located at the positive end of the component.

The second component is now clearly formed of the construct quiet vs noisy. A vagrant was seen as quiet while a mentally handicapped person and an alcoholic were seen as noisy. A mentally ill person was neutral on this axis. Therefore there was an improvement in the view of a mentally ill person.

Control Group- occasion 1: (see figure 2.3)

This grid is also very tight. It has a one dimensional data structure with the first component explaining 84% of the variance. The first component is formed of a bad/mad pole and a good/sane pole, with all the constructs highly split between these two options. An alcoholic, a vagrant and a mentally ill person lie at the bad/mad pole and all the other elements were more positive, although an unemployed person, a mentally handicapped person and a student were neutral.

The second component was not well demarcated, but to some extent it contrasts a vagrant with a mentally ill person, the latter being seen as more friendly and clean. This component might therefore be seen as something to do with homelessness.

Control Group - occasion 2 (see figure 2.4)

The first component explained 82% of the variance and the second a further 11%. Therefore the data structure was two dimensional.

The first component is composed of rough, looks different, aimless, depressed, not like you, changeable, angry, danger to himself and difficult to talk to vs safe, calm, stable, easy to talk to, cheerful, like you, purposeful, looks ordinary and polite. Again, a bipolarity of bad/mad vs the good/sane emerged. A vagrant, a mentally ill person and a mentally handicapped person lie at the bad/mad end, with the other elements at the good/sane pole.

DIFFERENCES IN CHANGE BETWEEN THE STUDY AND THE CONTROL GROUPS

Study Group: Delta Programme Analysis showed an overall low positive correlation between occasion one and two in the study group (0.27), that is to say little change between the two occasions. No change reached significance: the greatest change occurred on construct 10 (difficult to talk to) and element 5 (mentally ill person) (Sum of squares 28.7%).

Table 2.8 Study Group on Occasion One (Grid A) and Occasion Two (Grid B)

	Changes in Constructs Means		
Constructs	Grid A	Grid B	Ttest
1.Dangerous to himself	3.22	3.67	0.49
2.Dangerous to others	3.44	4.00	0.62
3.Angry	2.89	3.25	0.61
4.Aimless	2.56	2.92	0.52
5.Dirty	3.33	3.14	0.27
6.Rough	3.56	3.25	0.48
7.Noisy	2.78	3.14	0.40
8.Unlike myself	2.78	2.22	0.69
9.Depressed	3.00	2.69	0.45
10.Difficult to talk to	3.22	2.33	1.04
11.Changeable	2.33	2.69	0.57
12.Looks different	3.33	3.56	0.29
13.Unfriendly	3.78	3.58	0.29

Table 2.9 Changes in the Study Group Over Time
Changes in the Distances Between Elements

Elements	Sum of Squares	As Per Cent
1.Vagrant	55.366	10.23
2.Unemployed	37.884	7.00
3.Student	77.215	14.27
4.Healthy person	23.271	4.3
5.Mentally ill	155.21	28.69
6.Mentally handicapped	59.049	10.91
7.Alcoholic	21.495	3.97
8.Old age pensioner	108.831	20.12
9.Most liked neighbour	2.716	0.5

Control Group: Contrary to what was expected there were changes between the two occasions in the control group. The results of the Delta programme showed an overall positive correlation between the mean consensus grids of 0.11. Ttest showed the greatest change on the constructs rough/polite and dangerous to others/safe. The control group changed their opinion on the second occasion regarding the elements vagrant, old age pensioner and mentally handicapped, but most of these changes were as large as for the mentally ill as seen by the experimental group.

Changes in the Control Group Over Time

Table 2.10 Changes In The Constructs Mean

Constructs	Grid A	Grid B	Ttest
1.Dangerous to himself	3.89	3.22	0.64
2.Dangerous to others	5.00	4.00	1.66
3.Angry	4.22	3.14	1.31
4.Aimless	3.00	3.25	0.33
5.Dirty	4.44	4.14	0.40
6.Rough	4.44	3.81	1.93
7.Noisy	4.22	3.25	0.45
8.Unlike myself	2.11	1.67	0.65
9.Depressed	2.56	3.36	0.79
10.Difficult to talk to	3.11	3.33	0.23
11.Changeable	3.33	2.70	0.67
12.Looks different	4.11	3.56	0.78
13.Unfriendly	3.89	3.47	0.66

Table 2.11 Changes in the Control Group Over Time Changes on the Distances Between Elements

Elements	Sum of Squares	As Per Cent
1.A Vagrant	156.31	25.66
2.Unemployed	38.86	6.38
3.A Student	23.41	3.84
4.Healthy person	41.36	6.97
5.Mentally ill	63.91	10.49
6.Mentally handicapped	74.69	12.26
7.Alcoholic	70.80	11.62
8.Old age pensioner	91.47	15.01
9.Most liked neighbour	48.41	7.95

Comparison Between the Study and the Control Group in Their Perception of the Mentally Ill Person.

1. Relationships Between the Constructs:

While the study group used construct 12 (looks different/looks ordinary) to discriminate more between the elements; the control group used construct 11 (changeable/stable) to discriminate more between the elements.

In Tottenham group (the study group) tend to rate Element 5 (the mentally ill person) high on construct 3,13 (angry/calm) (friendly/unfriendly) and low on constructs 5,12 (dirty/clean and looks ordinary/looks different). While in Haringey group (the control group) tend to rate Element 5 (mentally ill person) high on constructs 10,8 depressed/cheerful) and (difficult to talk to/easy to talk to) and low on constructs 3,5 (angry/calm) and (dirty/clean).

That is to say, there is a negative association between these eight constructs.

Construct Correlation:

In Tottenham group constructs 1,2,9 (dangerous to himself, dangerous to others and depressed) were highly correlated with constructs 11,13,10 (changeable, unfriendly and difficult to talk to).

In Haringey group constructs 1,6,4, (dangerous to himself, rough, aimless) were highly correlated with constructs 2,7,11 (dangerous to others, noisy and changeable) at.964.

Angular Distance:

Both groups construed mentally ill relatively similar (the angular distance between element 5 (mentally ill) and all constructs range between 15.32 and 74.67. However, none of the constructs was completely similar or completely dissimilar. In the mean time none of the constructs were construed opposite to each other.

Deviation from construct mean:

In Tottenham group (study group), there was negative association between constructs 3,1 (angry and dangerous to himself), while in Haringey group there was negative association between constructs 9 and 3.

2. Relationships Between The Elements:

In both groups elements 1 and 7 (vagrant and person with alcohol problems) have the highest positive total, that is to say, undesirable people. While element 4 (person who is healthy most of the time) is the person that has the most desirable characteristics.

Distances between the Elements

In Tottenham group element 5 (mentally ill person) was seen similarly to the following elements: unemployed person, the person with alcohol problems, mentally handicapped and vagrant. In contrast, a mentally ill person was seen as dissimilar to: the person whom they like most, old age pensioner and the person who is healthy most of the time.

Even though in Tottenham group the mentally ill were viewed in the same way as in Haringey group, the distances between the mentally ill and the associated elements were slightly different. For example, in Tottenham group, a mentally ill person, an unemployed person, a person with an alcohol problem, a mentally handicapped person and then vagrant. While in Haringey group, a mentally ill person, a person with an alcohol problem, vagrant, a mentally handicapped person, unemployed and old age pensioner.

Relationships between Constructs and Elements expressed in Cosines:

In Tottenham group, mentally ill was construed as angry, unfriendly, changeable, dangerous to others, aimless, depressed, difficult to talk to, dangerous to himself, noisy, not like themselves, dirty and looks different - elements 3,13,11,2,4,9,6,10,1,7,8,5,12 respectively.

In Haringey group, mentally ill was construed as difficult to talk to, not like myself, changeable, depressed, aimless, dangerous to others, noisy, rough, looks different, dangerous to himself, unfriendly, and angry - elements 10,8,11,9, 4,2,7,6,12,1,13,5,3 respectively.

Descriptions of the Results Using MANOVA :

Public Attitudes toward the Mentally Ill

As shown in Tables 2.12 and 2.13, Mentally ill people were viewed negatively in both areas (study and control groups) before and after psychiatric patients moved into their neighbourhood (mean score was 10.48 on the first occasion and 8.91 on the second occasion). On the first occasion (before patients moved to the area), there was a tendency for the mentally ill to be seen more negatively by the study group than the control group (mean score for the study group was 5.82 and control group was 14.20). The results

showed a significant difference between the subjects by areas (Tottenham and Haringey) groups (p=0.003). However, no significant difference was found between first and second interviews. Similarly, no significant difference was found in the interaction between occasion and locality.

In both areas there was maximum disagreement in evaluating the mentally ill (scatter of ratings was std. dev. 10.43 in both groups on the first occasion, and std. dev. 11.15 on the second occasion). Interestingly, in the study group the disagreement regarding perception of the mentally ill was higher at the second interviews - std. dev. score reached its maximum, 10.52 on the first occasion and 11.3 on the second occasion.

Table 2.12 Basic summary statistics for the elements for both study and control groups (first occasion) (N=18)

Elements	Mean	Std Dev	Minimum	Maximum
A vagrant	18.14	9.25	0.33	32.56
A student	6.02	10.44	19.44	19.00
An unemployed person	3.36	7.30	18.00	19.11
A healthy person	13.52	5.36	24.33	4.33
A mentally ill person	10.48	10.43	8.33	34.11
A mentally handicapped person	2.14	10.21	14.89	26.67
A person with alcohol problems	13.53	9.96	6.89	32.56
An old age pensioner	9.8	6.19	19.00	3.33
Most wanted neighbour	11.58	7.65	24.33	5.44

Table 2.13 Summary Statistics for the elements for both study and control groups (second occasion) (N=18)

Elements	Mean	Std Dev	Minimum	Maximum
A vagrant	15.35	8.56	2.33	27.89
A student	9.04	6.83	21.78	5.44
An unemployed person	3.32	10.22	18.11	17.89
A healthy person	11.98	5.87	22.78	0.89
A mentally ill person	8.91	11.15	10.11	30.33
A person with mental handicap	11.13	10.22	8.44	25.89
A person with an alcohol problem	9.85	12.12	12.67	30.33
An old age pensioner	8.54	7.24	18.11	8.11
A most wanted neighbor	12.31	6.17	26.78	1.11

Table 2.14 Basic summary statistics for the elements for the study group (first occasion) (N=8)

Elements	Mean	Std Dev	Minimum	Maximum
A vagrant	14.07	9.06	0.56	26.00
A student	6.31	8.41	17.56	6.00
An unemployed person	0.68	4.40	6.33	6.67
A healthy person	12.18	6.92	24.33	4.33
A mentally ill person	5.82	10.52	8.33	19.22
A mentally handicapped person	4.20	7.34	5.56	16.67
A person with an alcohol problem	13.45	7.48	0.00	22.67
An old age pensioner	8.56	6.11	19.00	0.00
A most wanted neighbour	9.80	9.92	24.33	5.44

Table 2.14 on the second occasion (after patients moved to the area), the study group showed slight changes in their attitudes from positive to negative (mean score was 5.82, and became 2.14), while the attitudes of the control group remained the same (mean score was 14.20 and became 14.32).

SUMMARY STATISTICS FOR THE CONSTRUCTS

Summary statistics were carried out on all the constructs data pooled for both the study and the control groups on both occasions. In the study group, first occasion, it was found that the constructs 3, 8 and 10 (angry/calm) (not like myself/like myself) discriminate most. While constructs 5, 7, and 12 (dirty/clean) (noisy /quiet) and (looks different/looks ordinary discriminate less. In the second occasion, constructs 4 and 12 (aimless/purposeful) and (looks different/looks ordinary) discriminate less. While constructs 2 and 10 (dangerous to himself/safe) (difficult to talk to/easy to talk to) discriminate most.

In the control group, first occasion, constructs 2 and 11 (dangerous to others/safe) (noisy/quiet) discriminate most. While constructs 3 and 4 (angry/calm) (aimless/purposeful) discriminate least. In the second occasion, constructs 11 and 12 (changeable/stable) (looks different/looks ordinary) discriminate least. While constructs 5 and 10 (dirty/clean) (difficult to talk to/easy to talk to) discriminate most.

Summary of the study and the control groups ratings of the elements on all the constructs on both occasions. The data of all the ratings for the 9 elements on the first and second occasions for both groups were summed and the differences between the ratings on both occasions was calculated.

Results of the study group:-

The results of the study group showed that individuals' ratings for the 9 elements varied across the elements ranged between 3 to -38 (Table 15). There is no particular pattern detected between the ratings of the elements. Likewise in the control group individuals showed diversity of rating(Table 16). On the whole, the study group showed greater changes between the first and second occasion than the control group (e.g. more positive changes).

Studying the ratings of both groups on element 5 (the mentally ill) one could conclude that the individual's ratings in the study group have changed their view of mentally ill people. The change was generally in the positive direction (Mean is 2.6 and SD 20.5). Only 2 individuals out of 8 showed negative change in their views towards the mentally ill. In the control group the individuals viewed the mentally ill relatively similarly on both occasions. Five individuals out of 10 showed slight negative change. These subjects viewed the mentally ill exactly the same on both occasions (the change between 0 and 2) and only 2 showed relatively high changes in their views of the mentally ill between both occasions.

Table 2.15 The study group ratings for the mentally ill on two occasions

Subject no.	Occasion (1)	Occasion (2)	Differences between 2 occasions
1	59	21	-38
2	43	59	16
3	21	45	24
4	35	45	10
5	65	48	-17
6	23	29	6
7	36	53	17
8	62	65	3

Table 2.16 The control group ratings for the mentally ill on two occasions

Subject no.	Occasion (1)	Occasion (2)	Differences between 2 occasions
1	41	37	-4
2	28	28	0
3	29	31	2
4	32	34	2
5	46	38	-8
6	17	49	32
7	37	35	-2
9	42	36	-6
8	35	51	16
10	25	13	-12

2.10 DISCUSSION OF THE REPERTORY GRID RESULTS

In the next section the results of the study will be discussed under the following headings: (a) Methodological critique of the study. (2) Hypotheses of the study:

2.10.1 Methodological Critique of Study

RG was used with a small selected group of members of the public who were willing to participate in the study. These members are likely to be more intelligent and possibly less prejudiced; therefore one cannot generalise the results from this small sample. The value of the R.G. data in this study lies in their use as a check on the findings of the semi-structured questionnaire rather than as an independent data set. Even though it was a complicated process to try to compare the results of both the questionnaire and the grid, it was a helpful exercise because it showed that there is a consistent trend between the results of both tools.

Analysis of the data is a complex procedure. The findings are not self-evident from the raw data. There is a need to employ a high level of abstraction, therefore, interpretation of resultant factors require special skills.

Like any other scales RG is susceptible to several common problems such as social desirability response bias, although it is less obvious to the subject what the desirable response is than with a questionnaire. An extreme response set results from the fact that some people consistently express their attitudes in terms of extreme response alternatives (e.g. "strongly agree") as opposed to others who endorse middle-range alternatives.

Administration of the RG is also time consuming. In addition, the use of a new grid made comparisons of results across studies difficult.

2.10.2 Discussing hypotheses of the study

What resulted from the RG interviews was a mass of data containing personal perceptions, beliefs, experience, and attitudes which portray the local residents' beliefs about the mentally ill.

In this study two major factors or dimensions of perception emerged. The first of these factors was "bad/mad" which particularly reflected the public experience of the mentally ill: fear, unpredictable behaviour and difficulty in communication. The second factor was "social distance perception" which reflects an image of mentally ill people as strange, bizarre, and unfriendly.

Overall there was more underlying agreement than disagreement in terms of how the constructs relate to each other for different individuals. There was also equal stability over time of constructs' relationships for the two areas. The results of the reliability were supportive of the use of consensus grids.

In the folowing section the results will be discussed in the light of each hypothsis:

2.10.2.1 There is no differences between the study and control groups' attitudes towards mentally ill people on the first occasion.

The grids supported the hypothesis that there was no difference between both groups on the first occasion in that they construed mentally ill people in the same way. In applying W as an index of the divergence of the agreement between the 18 subjects it was found that the subjects applied the same standard in ranking the degree of association between the 234 variables.

Kelly (1983) suggested that the similarity in construing things between individuals does not mean they have had similar experience, rather that they have placed the same interpretation on the experience they have had.

Therefore one could suggest that the general stigma attached to mental illness has affected people's perception of the mentally ill person.

However, one could propose that disagreement between local residents might emerge in time, once awareness grew of different types of behaviour and the initial apprehension diminished.

2.10.2.2 The behaviour of psychiatric patients has no effect on the attitudes of the study group.

As expected there appeared to be considerably more movement of elements in the consensus grid of the study group than in that of the control groups. A vagrant moved towards quiet on the second dimension as did a mentally ill person though to a lesser extent. This indicated that local residents construed mentally ill people as similar to a vagrant person. This result is particularly important to the staff to try to improve patients' appearance and to involve them in a structured programme of activities to keep patients occupied at the mental health facilities. There is also a need to educate the public about the patients' circumstances at the hospital, namely that part of the patients' leisure activities is walking around the large hospital grounds, therefore wandering around the streets represents a leisure activity rather than vagrancy. Considerable movement was recorded for a mentally handicapped person, who was almost exactly opposite a student, which indicated that the public discriminated between a mentally handicapped person and a mentally ill person on the second occasion, associating the former with low intelligence as opposed to a student.

The joined plot of all the mean grids showed little positive changes in the major attitudes to the mentally ill, but there was a change in minor attitudes like noise and minor local disturbance. It could be that after patients lived in their area there was a change in the local residents' opinions of the likelihood of minor irritations.

Contrary to what was expected, the data structure in the control group on the second occasion was loose and less similar to the study group on the second occasion. In general second grids should be tighter than first grids. Since it occurred to much the same degree in both the study and control groups, this cannot be due to the effect of the location of the psychiatric patients' facility and in the control group could be put down to:

1. An artifact of the experiment. It is likely that the interviews stimulated people's thinking, and their ideas were somewhat more differentiated as a result.
2. Confusion of mentally ill person with another element on the first occasion. Subsequently, the distances between the elements revealed great diversity between a vagrant and a mentally ill person, that is to say the respondents indicated less confusion between these elements on the second occasion than the first as shown by the Delta results. It would be appropriate to mention that during the interviews, the respondents pointed out that there was a large number of vagrants in their area, wandering about and causing some damage to local community facilities.

However, there was no substantial revision of the perception of the mentally ill person in the control group between occasion one and two in this pair of grids. The second component is not well marked but is formed of a vagrant - unfriendly and dirty vs clean and polite. A mentally ill person is now less positive on this component. It seemed that local residents' attitudes to a mentally ill person worsened slightly in the control group by occasion two.

2.10.2.3. There is no difference in the rank order of degree of reactions towards mentally ill people in both groups.

The results rejected this null-hypothesis. It was obvious that people perceived the mentally ill negatively, as all the positive constructs were located at one pole and all the negative ones were at the opposite pole.

There is more inter-subject agreement concerning the pattern of relationships among the negative poles of constructs than that among the positive poles. Adams-Webber (1980) found that the meaning of the negative poles of constructs are more differentiated than are those of their positive poles.

2.10..2.4. There are no constructs that are more specifically associated with mentally ill than other elements.

This null-hypothesis was also rejected. The results obtained showed that some constructs have remained stable in their association with the mentally ill in both groups such as difficult to talk to, dangerous to himself, changeable, unfriendly and aimless. The

principal component analysis showed that the changes are interrelated and concentrated in quite a small number of dimensions.

Both groups showed a tendency to view the mentally ill person as different from themselves on construct eight (unlike you). Kitsuse (1962) and Loman (1976) argued that prejudice stems from the assumed belief of dissimilarity between oneself and deviant people. This could explain the way in which local residents arranged themselves in the opposite direction to various minority groups.

Similar findings were obtained by Agnew and Bannister (1973) who carried out an experimental study in which eight consultant psychiatrists completed four grids. Each psychiatrist selected twenty patients with whom they were familiar. At the beginning of the experiment each psychiatrist divided their patients randomly into two groups of ten and rank ordered them in terms of eight diagnostic labels such as neurotic, psychotic etc. and ordered the second group in terms of lay psychological constructs such as reliable, likeable etc. After one month the study was repeated with the reverse order of group ranking. The results showed that the degree of interjudge agreement about the relationship between constructs was not higher when the psychiatrists were using their professional psychiatric terms. That is to say the two languages were contaminated by the idea 'neurotic' is 'good' and 'psychotic' is 'bad'. There was equal stability over time of construct relationships for the two languages.

Kelly suggested that lessening prejudice should involve change in the way we construe the prejudiced object. It would be effective if we tried to help people to recast their construing strategies altogether, rather than directly attempting to persuade them that the object of prejudice is acceptable.

2.10.2.5. There are no elements that are more specifically associated with the mentally ill than other elements.

Again, this null-hypothesis was rejected. The results showed that some elements were construed in the same way as the mentally ill in both groups on both occasions, such as vagrant, alcoholic and mentally handicapped person, while other elements were more specifically distant, such as person you like most as a neighbour, person who is generally healthy, and the unemployed.

6. How "simple" is the grid?

The local residents viewed the elements in a simple form either positive or negative which resulted in the emergence of a good/bad pole and polarisation of the constructs. Principal Components Analysis showed that the first and second components explained more than 80% of the variance.

Other explanations of the extremity of the ratings were proposed by Cromwell and Caudwell (1962) who suggested that ratings are more when subjects use elicited rather than supplied constructs. Slater (1967) added that subjects use polarisation for salient or important constructs.

One could add that the simplicity in construing the elements could be due to the fact that the respondents were working class and viewed the world in a simple way (Warren, 1966), or that they had little contact and experience with the elements represented. Crockett (1965) has argued that individuals having greater involvement with others develop more complex systems of constructs to represent and interpret other persons' actions.

2.10.3 Conclusion

There were considerable similarities between the study and control groups on the first occasion, although the control group perceived the mentally ill somewhat more negatively. On the second occasion the study group showed positive but not significant changes in their perceptions of former psychiatric patients moved to live in their neighbourhood. However, the control group showed negative changes in their attitudes towards mentally ill people, and it appeared that they may have confused the mentally ill with vagrant people. Both groups perceived the mentally ill as unpredictable, difficult to communicate with, strange and unfriendly. The marked apprehension which the local residents felt suggests the need for education in improving public attitudes and for rehabilitation. Education programmes should focus upon areas in which attitudes are most negative.

3. PATIENTS' STUDY

TRANSITION OF PSYCHIATRIC PATIENTS INTO THE COMMUNITY

3 INTRODUCTION

In this section problems of the transition period in relation to psychiatric patients will be discussed. Areas of discussion will include: problems related to long-stay patients, factors affecting patients' adjustment in the community such as preparation required before moving to the community, patients' behaviour and their attitudes to the services. Other issues relating to the effects of community care on the patients will be considered, such as quality of life and social networks.

3.1 PROBLEMS OF LONG-STAY PATIENTS

The terms 'chronic' and 'long stay' do not only describe the patient's mental state, but also the person's everyday behaviour. Long-stay psychiatric patients have disabling behaviours that may be resistant to change. These behaviours can also be complicated by various physical problems as well as socially unacceptable habits that could interfere with their re-integration in the community.

There is a body of opinion that institutionalisation has significant effects on long-stay patients, leading them to become apathetic and withdrawn due to loss of individuality. Barton (1970) identified the features of institutionalisation that led to the end state of the chronic patient as: a. loss of contact with the outside world, b. enforced idleness and irrelevant activity, c. bullying, violence or teasing, bossiness of staff and rigid staff/patient roles. d. loss of personal friends, possessions and events, e.sedatives and tranquilizes, f. stagnant and non-purposive ward atmosphere and regime and g. loss of prospects outside the institution.

Goffman (1961) described the mental hospital in terms of the concept of the 'total institution' which functions apart from society, behind social, economic, geographical and other barriers. The separation between the institutionalised psychiatric patients and society was both explicit (for example remote location, restriction on the residents' freedom of movement) and implicit (for example policies, rules and roles that emphasise a protective and restrictive environment which is seen to be required because the 'patient' is ill).

Wing et al (1961) studied the effects of the institutional environment and its manipulation on a series of deficits, detected in samples of chronic schizophrenic patients in different mental hospitals. They showed a strong association between the presence of poverty of speech and flattening of affect and an impoverished environment and lack of social stimulation.

Owens and Johnson (1980) surveyed 500 long-stay schizophrenic patients in Shenley Hospital. They found that these patients were suffering from abnormalities in their mental state, cognitive functioning, neurological status and behavioural performance. Highly significant correlations were found between the impairment of the four areas of the

present state . The preliminary results indicated that these impairments are likely to be an integral part of the disease process, thus contradicting the view that the institutional environment is responsible.

Brugha et al (1989) carried out an assessment of the physical needs of 145 long-term users of social services and day psychiatric facilities. They found that 41% had medical problems requiring treatment, but 39 out of 145 had unmet needs. The results also showed poor compliance with attendance and treatment arrangements.

As long-stay patients' behaviour is a manifestation of their institutional behaviour, with the closure of psychiatric hospitals two problems face former psychiatric patients in the community, firstly how far the public will perceive their behaviour as normal, and secondly,the type of accommodation to replace the institution.

3.2 FACTORS AFFECTING PATIENTS' ADJUSTMENT IN THE COMMUNITY

Various studies have been carried out on patients who had already moved to the community. In this section, factors considered by these studies to be contributing to patients' adjustment in the community will be described.

3.2.1 Public perceptions of mental illness

Public perception of mentally ill behaviour as unpredictable and aggressive could be one of the major blocks to community care. Ellis (1967) discussed the consequences of labelling somebody mentally ill as it might enhance his feelings of shame and h/she might resist to accept the seriousness of his disturbed behaviour and therefore does not seek help or even resist any help for his condition or opportunities to help themselves. People with various adjustment problems or idiosyncratic ways of living. That an individual who at the present time is behaving in a self defeating and/or needlessly antisocial manner is still not to be condemned for creating it and is to be helped to overcome it.

It is important to change our evaluative attitudes by educating the public as well as professionals to accept the emotionally disturbed without restriction. This could be done by operational definition to the term "mental illness" and change current psychological usage and not negatively evaluated as human being.

Factors affecting former psychiatric patients were studied by Miller and Dawson (1965) indicated that stigma is not equally experienced by all ex-psychiatric patients. They studied 249 psychiatric patients readmitted to a state mental hospital after their discharge. Both patients and their significant others were asked whether or not their admission to a mental hospital had created any difficulty for readjustment in the community. Where as 44% of the patients said that they had difficulty, 58% of the significant others felt that the patient had created a stigma for his family in the community.

In addition, Miller and Dawson (1965) carried out a longitudinal study of 1,082 ex-psychiatric patients and 163 patients who are readmitted to a state hospital and their families. The purpose of the study is to investigate the ex-psychiatric patients awareness with stigma of mental illness and its effects it has upon their re-employment. Using content analysis method, the researchers described four types of stigma effects:

1. Stigma of mental illness used as threat: 16% of the patients [largely middle aged wives] readmitted to the hospital after their discharge gave evidence of the effects of this stigma.
2. Stigma resulted in blocking communication with friends and family. This stigma led to destructive change in patients' perception of their self and in the quality of their communication with others 16% has indicated this form of stigma.
3. Self-derogation [lack of self confidence] 35% indicated that even though they were able to work, but as a result of lack of confidence and self esteem they made little or no effort to seek employment.
4. Stigma led to lack of re-employment, 36% of patients had employment before admission, 20% found employment after discharge 33% subjects indicated that being a former patient had directly affected their holding of employment. They concluded that feelings of stigma are a factor in the re-employment problems facing ex-psychiatric patients. However, the researchers could not identify the exact type and amount of stigma of mental illness.

Fracchia et al (1976) pointed out that public willingness to accept former psychiatric patients in the community might depend on their stereotype of how the mentally ill behave. Their results showed that the public perceive the mental patient as potentially explosive and difficult to understand. This tendency to associate dangerousness with unpredictability, and the consequent fear, could explain public rejection of mental health facilities in their neighbourhoods. Fracchia suggested "that the medical model appears to have been accepted, and perhaps an informational educational programme should re-directed professionals' efforts towards breaking that bond".

This raises the question of how far a person is required to change to fit social norms, or whether social values can be made more flexible to accommodate many of those who are now seen as outsiders.

3.2.2 Patients' characteristics

Davis et al (1957) investigated factors associated with successful community adjustment for 59 former psychiatric patients. The criterion for identification of these patients was living in the community for at least two years. Most patients were interviewed as well as their families (n=43). Factors identified were: high on interpersonal performance, full time workers or responsible for the care of their homes (50%), participating in formal and informal social activities. Patients who returned to parental

homes did better than those who returned to conjugal families. For patients with a high level of performance, families attributed the cause of mental illness to environmental factors rather than heredity. These relatives also had positive views towards hospitalization, and they considered that mental illness does not change the person himself.

Similarly, Hamilton and Hoenig (1966) studied factors that led to hospital admission in spite of an extramural scheme in a general hospital in the Manchester area aimed at avoiding psychiatric hospital admission. After four years follow-up they found the main factors were: the degree of family burden, patients' dangerous behaviour, single males, schizophrenic, under sixty years of age and with a small household.

Fernando et al (1990) conducted a similar study in a Southern Ontario psychiatric hospital in order to identify factors related to successful post hospital discharge. They studied a group of 70 patients who were maintained in the community. Factors detected from the time of their discharge till the time of readmission, were: compliance with medication, and the level of discharge planning. Demographic characteristics such as diagnosis, severity of condition on admission and number of previous admissions, exerted no effect on maintaining patients in the community.

3.2.3 Patients' role in their community

Wolfensberger (1972), argued that socially valued roles encourage deinistitutionalization, and change attitudes towards disability. Wolfensberger introduced the concept of social role 'valorisation'. He suggested that if the deviant group adopted a life style which was more socially normative and less segregated, and participated in socially valued roles, the attitudes of society towards deviance and segregation could be improved.

Whorly (1978) considered the concept of 'social profitableness' a crucial determinant of community acceptance of former psychiatric patients. He explained 'social profitableness' in terms of the social costs of former psychiatric patient's behaviour to other citizens through its deviant nature. Whorly (1978) suggested that the mannerisms of former psychiatric patients were often viewed by the public as an alarm for unpredictable and threatening behaviour. He gave an example of the cost of institutionalised behaviour to the public; when patients' eating habits and poor hygiene irritate other customers in a restaurant, resulting in loss of pleasure in the meal. 'Social profitableness' is central to the behavioural theory of social exchange as established by Homans (1961) and Siassi et al (1973) and Shpiro et al (1974).

Similarly, Longabaugh et al (1966) described social interaction with former institutionalised patients as 'socially bankrupt', that is to say, interaction with chronic patients is un-profitable in that their deviant behaviour outweighs what they can offer.

In order to increase the possibility of reintegration of former psychiatric patients into the community, Whorley (1978) suggested that rehabilitation programmes should attempt to eliminate the costly behaviour of the chronic patients. Therefore, re-socialisation programmes should teach the patients appropriate behaviour, social skills and simple tasks that could be profitable to the local community as such fund raising or cleaning the environment.

3.2.4 Preparation of patients for transition

The decision concerning readiness of psychiatric patients for community living is a crucial one, involving staff skills as well as patients' ability to cope with their community living. Key & Legg (1986) pointed out that the identification of patients for community living is often based on informal, non-validated criteria.

Problems of assessing the needs of long-stay patients:

These are some of the problems that could affect rehabilitation plans for long-stay patients undergoing discharge to the community:

1. Inability of psychiatric patients to identify their needs.
2. Inability to make decisions due to deep emotional distress.
3. Patient's unstable mental state.

Old long-stay psychiatric patients pose a dilemma for hospital closure plans and raise the question of the need for asylum. They still inhabit the back wards of many large psychiatric hospitals and represent the majority of the institutional population. Wing and Brown (1970) pointed out that successive governments failed to plan proper reprovision. The Government White Paper 'Better Services for the Mentally Ill' (1975) summarised the problems of old long-stay patients as *"Many of them are still in hospital not because they need specialist hospital services but because they either need other forms of shelter and support, which are not at present available outside hospital, or they have become so accustomed to hospital life, so institutionalised, that it would be inhuman to discharge them from the hospital that has in effect become their home".*

Ekdawi (1989) in the annual rehabilitation study day at Netherne Hospital discussed the challenging problems of long-term severely disabled patients in the era of care in the community. He indicated that the mental hospital's role of providing asylum to the severely disabled patient is essential and that this role has not been established in the community.

3.2.5 Rehabilitation of psychiatric patients

Rehabilitation of psychiatric patients is crucial for community care in order to integrate former psychiatric patients into the community rather than just "containing" them there. Rejection of mentally ill behaviour by the public and the failure to reduce the social distance between former psychiatric patients and their immediate community are barriers to

community care. Failure of this policy would be painful for both the patient and the public.

Rehabilitation is described by two schools of thoughts: the medical model and normalisation. Each of these has its advantages and disadvantages. The 'medical model of care' for example fails to identify the needs of chronic psychiatric patients. The negative aspects of the 'medical model' as outlined by Wolfensberger (1972), are : perceiving the individual as a 'sick patient' who after diagnosis is given treatment. The concept of curability versus in-curability because of the perceived 'chronicity' of the condition. Occasionally the individual takes advantage of the 'sick role' such as exempting themselves from normal social responsibility.

Wolfensberger (1972) pointed out that the principles of normalisation have offered ideas of good practice of mental health services. He emphasized that normalisation is an approach to service reprovision rather than a theory. It provides guidelines for rehabilitation,it aids the understanding of behaviour in its context, and enhances the ability of the user.

Wing and Brown (1970) found improvements in patients when their general environment was enriched and especially when the amount of time spent doing nothing was reduced. However, only 21% showed definite improvement over time, a further 10% derived some benefit, but the majority were unchanged. They emphasised the possibility of the effects of biological processes on patients' behaviour.

The White Paper (1989) noted that a case manager system and a properly integrated programme of care might meet the needs of seriously mentally ill people in the community. Falloon and Shanahan (1990) added that successful clinical management of schizophrenic patients in the community required skilled neuroleptic drugs provision, stress management, skills training and appropriate psychological intervention. In addition to professional co-operation, incorporation of patients and their families into treatment programmes is essential.

Webb et al (1986) measured changes in the behaviour of 24 mentally handicapped people who moved from the hospital to the community. The results showed that patients' everyday behaviour remained unchanged but some adaptive skills and interactive behaviour declined. They concluded that maintaining the hospital training programme after the patients' discharge into the community has more effect than the normalisation approach in developing and maintaining residents' adaptive behaviour.

3.2.6 Community support services

Experience in community care has shown that the quantity and quality of reprovision in the community are essential in psychiatric patients' survival. Bollini and Mollica (1989) in their evaluation of the Italian reform movement found that reorganization of the services delivery system was crucial in the reform's success.

Thornicroft (1989), (TAPS report 1990) pointed out that alternative reprovisions in the community were not more expensive than in-patient care and patients had not deteriorated as expected.

Crepet (1990) examined the transition period after 10 years of the Italian psychiatric reform. He found a gradual decrease in the number of in-patients accompanied by an increase in the out-patient district services. However, the quality and quantity of these services remain inadequate. The mental health of the general population remained unaffected.

Haveman (1989) studied the possibilities of managing long-term psychiatric patients outside psychiatric hospitals. The researcher asked the attending psychiatrist and a psychiatric nurse to give independent opinions about which patient was suitable for alternative accommodation in a random sample of 381 chronic psychiatric patients in 5 Dutch mental hospitals. The results showed that 30% were judged eligible for alternative accommodation. These patients were younger, less frequently diagnosed as schizophrenia, better integrated inside and outside the hospital, more likely to be in a ward with a high turnover-rate, were less aggressive, with shorter periods of stay and had better social skills than the rest of the study group. There were no significant differences with regard to suicidal behaviour, organic brain syndrome and formal admission status.
Other studies tried to identify types of accommodation required in the community. Livingstone and Bryson (1989) described the Glasgow consultants' decision about patients suitability for rehabilitation and for community living. The survey showed that only one third of the patients were identified as suitable. These patients were characterised by younger age and a shorter period of in-patient care. Over 15% were thought to be able to manage in a ward or hostel within the hospital.

3.2.7 Patients' attitudes to community living

It has been suggested that patients' attitudes toward community living could affect their adjustment in the community. Drake and Wallach (1988) studied 187 chronic psychiatric patients' living preference as well as the relationship between living preference and re-hospitalisation after one year of their discharge. After baseline data were collected from records and the ratings of living preference were made, the patients were followed prospectively for 12 months. Patient's re-hospitalization was assessed, then the baseline assessments were repeated. The results showed that:

1. Living preference is related to past hospitalization history and to other factors that are widely believed to influence hospital tenure, such as severity of illness, social support and institutional policies. Patients' attitudes towards hospitalization represent a uniquely important synthesis of these factors.
2. Few of the patients (4%) preferred the hospital .

By contrast, Wing and Brown (1970) found a large proportion of long stay patients either wished to stay, or were uncertain about the idea of leaving hospital. Their respondents had little knowledge on which to form a view of leaving hospital and few supported facilities were available to assist them in making the transition.

However, Allen and Barton (1976) found that patients' attitudes become less positive after discharge or else they were undecided at the time of admission and shift their view in the direction of preferring the hospital at the time of re-admission. They considered that patients' attitudes could also be influenced by current clinical state and the tendency to comply with staff's attitudes. The relationship between living preference and hospital tenure were relatively independent of diagnosis. They suggested that patients who strongly desired to live in the community are likely to participate in treatment aimed toward that goal. On the other hand, a patient who is attracted to the hospital as a living alternative often hinders discharge planning unless the reasons for that living preference are addressed in the process.

Andrews et al (1990) carried out a follow-up study in New South Wales, Australia of 208 long-stay patients who were discharged to supported accommodation. They found that 172 patients expressed satisfaction with their accommodations, 78% preferred living in the community and only 7% preferred the hospital. Most patients were considered to be functioning well, although 22 of the severely disabled were re-hospitalised at the time of the study. Patients seemed to have benefited from supported accommodation and required low levels of mental health care.

3.2.8 Patients' quality of life in the community

Patients' quality of life outside hospital was considered by Lamb (1979/81) to depend on their living situation, how they spend their time, and the degree to which they are isolated from their community. Cohen and Sokolovsky (1978) and Lamb and Goertzel (1977) emphasised their financial condition, and Reich and Siegel (1978) their safety. Stein and Test (1980) and Marion and Grabski (1979) suggested that patients 'quality of life' could be improved by innovative community programmes.

Huxley (1986) and Thapa & Rowland (1989) in their definition of the quality of life distinguished between environmental quality and environmental condition. The former is a subjective assessment, while the latter could be measured objectively. Malm et al (1981) evaluated the quality of life of schizophrenic out-patients and concluded that it was influenced by four systems, namely: health care, rehabilitation, the family, and the community.

Lehman et al (1986) studied the quality of life of 2 groups of patients, 99 in-patients and 92 patients in various community facilities, both identified by random methods. Subjects of the study completed two structured questionnaires, one to describe their quality of life and the second questionnaire to identify their mental state. Patients

were divided into 4 groups: short-stay community residents, long-stay community residents, short-stay in-patients and long-stay in-patients. Quality of life was measured on 8 items such as: living situation, family social relations, leisure activities, work, finances, personal safety and legal problems, and health.

The findings showed that patients' quality of life had improved. Short-stay community residents showed a tendency towards higher rates of employment than long-stay community residents. They also had high arrest rates and greater dissatisfaction with their financial condition. Long-stay community residents had the highest level of life satisfaction, were rather settled in the community and felt no impetus to change. Short-stay inpatients were dissatisfied and poorly motivated.

The most salient finding was the difference in the degree of satisfaction between in-patients and community residence patients, the community residences providing more favourable environments for their patients than the institution.

One should recognise that the level of impairment of patients' behaviour undoubtedly affects the quality of the living environment.

Baker and Intagliata (1982) Lehman et al (1982) Lehman (1983) and Marion and Grabski (1979) identified the sources of greatest dissatisfaction for discharged patients as poverty, unemployment, lack of community services, poor health and problems with personal safety.

3.2.9 Patient's social network

There is a general opinion that patients' social networks play an essential role in their resettlement and support in the community. Former psychiatric patients who lived with their families felt slightly less difficulty than other patients. Former psychiatric patients who said they felt hardship more often felt unable to work or hold a job than non-hardship patients, even though they had tried and failed to get jobs. Skilled and semi-skilled ex-patients found difficulty to get jobs than skilled patients. Age and sex showed no difference in the degree of hardship. Lynch et al (1977), Budson and Jolley (1978) and Cohen and Sokolovsky (1978) studied residents of a large hotel in New York and concluded that schizophrenic patients had significantly fewer linkages than those with non-psychotic conditions, but that even the most impaired of them were not socially isolated. The researchers also concluded that the rate of re-hospitalization was related to their network size as well as to their mental state.

Abrahamson (1985) compared the social networks of patients with chronic mental illness in Goodmayes hospital and extra-hospital settings, as they moved through preparation houses on the hospital campus from one to the other. The researcher obtained a list of all those to whom a particular patient was linked and charted their interconnections as in Mitchell's (1969) strategy for personal networks. The study of 35 patients' social networks showed an unexpected increase. Although the size and density of relationships

were increased, the content of the networks was hospital and community staff, and patients and relatives, while there were very few contacts in the general community.

Pattison et al (1975) suggested that schizophrenic patients have smaller social networks than either neurotic patients or controls.

There have been very few studies of the social networks of patients in mental hospitals. There have been a few assessments of the social networks that developed amongst residents of halfway houses in the community and of the support they provide even after they have left the houses.

In addition, Hamilton (1989) studied the quality of the social networks of 39 people with positive versus negative psychotic symptoms. They found that patients with negative symptoms had significantly smaller dysfunctional social networks, while positive symptoms showed no effects on patients' social networks.

It could be concluded that mentally ill patients exhibit some symptoms that distance them from other people and influence their quality of life. People with long term psychiatric disabilities have a wide needs. More useful and creative planning to meet needs. They need treatment for mental, and physical disabilities personal relationships, activities during the day, leisure opportunities as well as attention to physical health.

3.3 Criticism of the Literature Review:

This review is restricted to studies whose main focus was on long-stay psychiatric patients. A review of follow-up studies showed little theoretical or methodological progress regarding factors conducive to improvement in patients' readjustment in the community.

Research in this area can be divided into 3 categories: 1. research on the impact of different types of in-patient treatment on post hospital adjustment, 2. research into the effectiveness of community based alternatives to hospital treatment. 3. identifying former psychiatric patients' characteristics which affect adaptation to life in the community. The most commonly used criteria for evaluation of patients' adjustment used are : Re-admission during a specified follow-up period, the proportion of time the patient spent in the community after their discharge, measures of social adjustment such as managing money and personal hygiene, and their clinical assessment.

The diversity in methodologies which have been employed, and in data collection methods, sample selection, study design, analytical procedures and approaches to the interpretation of results, made it difficult to compare between these studies. However, there is a widespread agreement on improvement in patients' condition in the community. In addition, no study has established a baseline assessment in the hospital to provide a comparison with follow-up assessment in the community such as the present study. The lack of baseline assessments and the absence of control groups from the studies reviewed

makes it impossible to separate changes due to the passage of time from the effects of moving patients from a hospital to a community setting.

Some studies investigated particular services and assessed their users, while others focused on individual patients and traced their progress through a variety of services. Studies carried out to evaluate the effects of hospital closure include those by Hamilton & Hoenig (1966), Lehman et al (1986) and Fernando et al (1990). However, all these studies neglected the effect of reprovision on the community, patients' integration into their neighbourhoods and public reactions.

Moreover, few studies tried to investigate patients' preparation before their discharge or evaluated any programme for their rehabilitation.

3.4 METHODOLOGY

NULL HYPOTHESES OF PATIENT'S STUDY

The results of this study will show that:-

There are no significant differences in patients' conditions while in hospital, and after 6 months and one year in the community regarding: their physical and psychiatric condition, their attitudes to living in the community, their social networks, their social behaviour and the degree of permissiveness of their environment.

Sample of the study

Twenty non-demented long-stay patients identified by The Grange staff were interviewed while in hospital, and six months and one year after living in the community. These patients have stayed more than one year in Friern or Claybury Hospitals.

Tools of the study

1. Non-participant observation conducted before patients' discharge to describe patients' preparation programme.
2. A structured interview with 20 patients who were living in or attending the Grange.

Description of the tools

Schedules used with the patients (Appendix 4) [all these schedules are currently in use by The Team for the Assessment of Psychiatric Services (TAPS) and are described in more detail in O'Driscoll et al, in press]

1. **Personal Data and Past History Questionnaire (PDPH).**
   It describes patients' characteristics before their discharge: age, length of stay in the hospital, reasons for admission and number of admissions as well as psychiatric diagnosis.

2. **Patient Attitude Questionnaire (PAQ) (hospital version).**
This schedule describes: patient's wishes toward leaving the hospital, what patient likes and dislikes and day-time activities.

3. **Patient Attitude Questionnaire (PAQ) (community version)**
This questionnaire which is a modification by the researcher of the hospital version describes: patient' reaction to community living, facilities and services, day-time activities, whether or not he noticed any change in himself, whether or not he feels that his life in the community is different from life in the hospital, and would he recommend the community place to a friend in the hospital.

4. **Physical Health Index (PHI).** This schedule describes patient's bodily illnesses, disability and care received.

5. **Social Network Schedule (SNS).** This schedule describes the size of patients' social network and the quality of relationships.

6. **Present State Examination (PSE).** Wing et al (1974) It describes patient's psychiatric symptoms and behaviour during interview.

7. **Patients' Social Behaviour (SBS).** Wykes & Sturt(1986). This schedule identifies problems in 20 areas of the patient's behaviour, including communication, appearance and activity.

PROCEDURES OF THE STUDY

At the time of the study, six of the clients started to attend the day centre on 14th May 1987 on a daily basis. The programme at The Grange included: 1. Looking after patients' personal hygiene; 2. Cooking and 3. Community orientation. On 2nd June the researcher started to assess the patients individually at The Grange.

1 Negotiation of access

Patients were approached personally and verbal consent sought. Patients were not pressed any further when there was an initial verbal refusal.

The clients were informed during one of their community meetings about the research and its objectives and confidentiality was assured. They were asked for their cooperation, and everybody showed interest in participating in the research.

2 Non-participant observation

Discussion of the researcher's aims and methodology was conducted with both patients and staff and they approved non-participant observation at the beginning of the project. However, at the time of arranging for the observations the day centre manager

expressed resistance to observation of the patients' rehabilitation programme and the staff discussion groups.

Then the matter was taken to the principal officer (mental health) at DSS and a meeting was conducted. In the meeting The Grange managers expressed anxieties regarding the research project. They were concerned that even though the research was confined to observation of the patients' programme of care, it could entail evaluation of the project itself. They also indicated that limited staff experience in the field made them insecure about the information they provided during their interviews. Reassurance was given by the researcher that staff training would be recommended.

However, in the face of this resistance,the non-participant observation was cancelled to avoid endangering staff co-operation with the other aspects of the research.

3 Interviews

Most patients participated in the study on both occasions. Refusal to participate in some of the interviews was either due to deterioration in their mental state or to the stress of moving from The Grange to other accommodation.

4 Reliability

Reliability of all the schedules used with the patients was established long before their interviews, in conjunction with members of the team where the researcher is based (Team for The Assessment of Psychiatric Services).
This was achieved in regular fortnightly joint rating sessions with the rest of the team.

3.5 THE GRANGE: AN EXAMPLE OF COMMUNITY MENTAL HEALTH FACILITY

Description of the Grange

Korman and Glennerster (1985) pointed out that Haringey Health Authority set up a task force team to advise and monitor the progress of the closure. It involved representation from hospital staff, health authorities, social services managers and from various project managers. The main model employed in planning has been that of 'Core and Cluster'. This involves a small number of centres [core units] which incorporate intensive rehabilitation facilities, accommodation and day care. The Grange has importance as a model for how the two services can cooperate on both clinical and planning issues in providing dual service rehabilitation as well as residential care.

The Grange is a listed Queen Anne building. It consists of a central part which operates as a 25 place day centre and the attached two wings functioning as living units for 12 residents. The Grange is situated in a working class area; multiracial dominated by Irish, Blacks, Asians, Turks and Italians. The houses surrounding The Grange are

council high rise buildings, terrace houses and factories. The road in which it is situated is a main road crossed by a high road with a good public transport connection.
In contrast to the hospital wards, The Grange is carefully decorated and furnished in a way that provides a high standard of living for the patients. Some residents had their own bed rooms, others shared their rooms. The space in the rest of the house is communal, but only the dining room brings closer interaction between individuals.

Discussion with The Grange organisers revealed that they view The Grange as a "stepping stone" for patients from both hospitals to the community. As the 12 residential patients are accommodated in the community, the 13 commuters gradually take their places in the residential unit, and new patients become commuters from the hospital, and so on.

The purposes of the Grange according to the social services operational policy are:

1. To provide final rehabilitation for life outside the hospital,
2. To initiate and develop activities according to patients' needs
3. To attain and maintain each client's maximum potential for independent living, by:
   a. assessment, with defined and stated levels of current ability.
   b. To design a programme of care with clear objectives to be achieved within a given period.
   c. To assess patients' progress continuously.
   d. To find permanent accommodation according to patients' needs.
   e. To provide continuous support following patients' discharge from The Grange.
4. The day centre will teach the patients skills of independent living. This will be achieved through developing training programmes about daily living.

Selection of patients for The Grange

At the beginning of the reprovisions and before the official opening of The Grange, several meetings were held between The Task Force Team at Friern Hospital and the project managers for jointly selecting patients for the project. However, considerable delay occurred due to difficulties in establishing assessment procedures. The selection and preparation process for the project was influenced by the policies of social services and health services.

Disagreement arose between the Task Force Team at Friern Hospital and the staff at The Grange regarding selection of the patients, for the following reasons:

a. From the social services point of view The Grange was designed to cater for clients of medium and low dependency. However, the Task Force Team considered it should cater for a high dependency group for which the hospital staff-patient ratio or the facilities insufficient to deal with their rehabilitation. Therefore, The Grange's staff was viewed as selecting the less dependent and

"easy person", leaving the hospital staff to cope with an increasingly problematic client group and lowering morale. Colin Kirk the Unit General Manager expressed his worries to Community Care Magazine (1987) that The Grange geared their services towards a kind of patient different from the majority of the Friern population.

b. The basic policy of the project. While the Task Force Team considered that the Grange should provide for 25 patients [dependent patients who require intensive rehabilitation] the staff at The Grange thought that they should cater for 20 patients who were moderately independent.

c. The Task Force Team in general favoured the use of 'social network' information to move patients with their friends, in addition to clinical assessment, while The Grange favoured an informal approach.

Failure of agreement led the hospital staff to withdraw their assessment procedure and The Grange staff went independently to the wards, interviewing patients and identifying a group themselves.

The Grange's staff official criteria for selection were the patient's willingness to move to The Grange, medium dependency, and absence of aggressive behaviour.
Even though certain patients were approached by the staff, it was entirely up to the patient to choose whether or not to visit The Grange. The staff reported that the most difficult part of the patients' transition was to persuade the patients to go to the Grange, and that they had to visit the wards several times to introduce or "sell" The Grange to them.

Patients, Preparaton

Preparation of the patients before their discharge. At Friern the Task Force Team was composed of one consultant, a CPN, a social worker, an O.T. and a psychologist, while at Claybury it comprised of a CPN and a community psychiatrist. At Claybury Hospital rehabilitation was an active part of patients' preparation using Hall and Baker's assessment scale. In contrast, at Friern Hospital The Task Force Team expected The Grange staff to conduct preparation and a rehabilitation programme for the patients.

The residents at The Grange had been prepared for the move largely by the hospital staff and within the hospital setting. These preparations were in the form of getting the patients ready to visit The Grange, arranging for clothing and financial supports, as well as contacting the patients' relatives.

The staff members at both the hospital and The Grange were positively encouraging of the patient to make the transition. Each patient had made a number of visits to The Grange, according to his ability to adjust to the move. Gradually the visits were increased from a few hours to a week before it was decided by The Grange staff that they were ready to move in. For all visits the patients were brought to the Grange by staff members in a Haringey Council van.

On 11th June the first five people stayed two nights per week. The purpose was for the staff to observe patients' behaviour and for the patients to familiarize themselves with the place and the area and prepare their meals. On 18th June these five patients seemed to have settled in, and were given leave from the hospital for 13 weeks. On 6th July, five more patients identified as commuters moved in on a trial basis.

In addition to having to work with a group of clients split between two hospitals with different approaches in each, the staff at The Grange encountered problems with some patients such as, lack of motivation, boredom, or negativism. They had to send two patients back to the hospital within 4 months of their trial period; one person because he thought that there was no difference between the hospital and The Grange, and the second person because she started to smear the toilet wall with faeces. The staff seemed to have failed to see this as a matter of learning to settle in and to live in a group rather than a pathological problem. This situation created a great deal of arguments with the hospital staff.

Confusion and uncertainty of the transition period

Even though the staff believed that the ideology of The Grange would help patients to settle outside hospital. There was a lack of clarity about their objectives and confusion over a number of issues. For example, they moved six patients (commuters) to accommodation in the community before a period of residence in The Grange as originally planned. At that stage, the actual policy regarding number of patients was still not decided on. Generally, the staff considered 20 patients enough to cope with. They also claimed that the physical arrangements of The Grange could not cope with more than 20. In addition, they could not decide about the assessment procedures or plan programmes for rehabilitation. Confusion was also extended to what I was doing as a research worker, and what I would do with the results of the study, and anxiety was expressed regarding the research project.

The staff found difficulty in coping with the residents. From their point of view there was a risk involved in looking after these patients. In addition the staff felt that they needed time to adjust to their roles and to acquire the experience to deal with mentally ill people.

The staff at The Grange made an agreement with Claybury Hospital that the patients would take 13 weeks' leave from the hospital. If any relapse occurred, patients would go back to hospital. If they settled in at The Grange, they would be discharged from hospital. Haringey Social Services bought nine beds from Claybury hospital in case of patients' relapse after 13 weeks. This arrangement clearly reveals the uncertainty of The Grange staff about the success of their programme.

Assessment of progress

There was no formal assessment of patients' progress, although the staff used to discuss their patients during regular weekly meetings. A few months after patients'

attendance at The Grange the staff started to keep some basic reports and records for their work and to record patients' progress. In addition, there was a monthly meeting between the staff at The Grange and the staff at Claybury to discuss patients' progress and to give feedback about the patients. But there was no such arrangement with Friern hospital staff.

Medication

For the commuters, the hospital consultant organised their medication so that the patients could have one dose before they went to The Grange and one when they returned to the hospital. This reduced the burden of administering the medication. For the residents, the staff had to administer this themselves.

Patient Programme

The issue of what type of activities are needed to encourage integration in the local area appears to have been ignored. The main staff concern was to find something for the patients to do during the day. The patients in this study were presented with little choice. Their programmes mainly consisted of activities such as: several outings to the local facilities and sight seeing, community meetings, warm-up, jewellery, tie dying , cooking and art. The staff themselves felt that they had very little support, and felt under pressure from professional staff at the hospitals.

The daily routine at The Grange

It can be described as semi-structured. There was no rota for domestic chores. The residents usually had a snack breakfast and were then expected to attend the day centre at 9 am where the day centre staff took over. A van driver collected the commuters from both hospitals. Day-time activities were flexible depending on clients' needs and the availability of services. Lunch and supper were prepared by a cook and were communal. At weekends snacks were prepared by the staff with some contribution from the residents. Shopping and meal planning was supposed to be done by the residents with the help of the staff, but in practice was generally done by the staff.

The role of the residents in housekeeping was limited. The daily routine was planned around the assumption that residents were normally engaged in the day centre activities. The daily housework was done by a cleaning lady. The presence of commuters and residents added to the complexity of the situation, especially as the commuters were not regular at attending daily. Commuters' attendance varied from a few hours a day to 5 days a week depending on their ability to adapt. The staff were not rigid regarding patients' participation in the day centre activities. Evening and week-ends were the residents' own. Residents watched TV or chatted. On some occasions residents were invited by the hospital staff to have Christmas dinner or attend a party on their previous wards. Outings, personal hygiene, cooking, and social skills were the centre of the day's activities and were organised according to the patients' needs.

Staff Approach

Most staff members had a limited amount of knowledge about psychiatric illness. Their interaction, concept and approach to community care included a lot of 'commonsense' and 'normalization' terms in its broad sense.

Some staff members reported their first contact with psychiatric hospitals was when they visited the prospective patients on their wards to introduce the Grange to them. As most of the staff had voluntary or residential care work experience, they relied on members with nursing training for guidance and information The staff on the whole were committed and motivated. On Wednesdays the commuters did not attend the day centre as all day centre staff spent the day in a meeting to discuss their work and their relationships.

The relationships between the staff and the patients were relatively close due to proximity rather than direct interaction. Residents were allowed access to their files [staff progress reports] as well as to the kitchen and food stored in the cupboard, as long as they kept the kitchen clean and tidy after use. Generally patients were interested in the outings rather than any other activities within the day centre.

Contact with the public

Before the official opening the Council made an announcement about The Grange in a leaflet distributed to local residents. The staff went round the local shops before the opening day of The Grange inviting them. They put up a banner on the building announcing its opening. Nearly all the shopkeepers visited The Grange, but less than a handful of the local residents. At Christmas, the staff organised a Xmas bazaar, and posted an invitation to the local residents through their letter-boxes, but very few came to the bazaar.

3.6 RESULTS OF THE STUDY OF TWENTY PSYCHIATRIC PATIENTS MOVED FROM HOSPITAL TO COMMUNITY: BASELINE, SIX MONTHS AND ONE YEAR FOLLOW-UP

This section is concerned with a study of 20 patients identified by the staff members at community mental health facilities. Identification of patients is the first step in the process of hospital closure to facilitate patients' transition from the hospital to the community. These patients were selected for an intensive rehabilitation programme in the community jointly run by the Social Services and Local Health Authority. The facility is a day centre, but also has places for residential care.

The objectives of this analysis are to identify:

1. Patients' characteristics.
2. Patients' physical state.

3. Patients' reactions towards their discharge.
4. Patients' mental state.
5. Patients social behaviour.
6. Patients social networks.
7. Characteristics of the environment of the community facilities.

3.6.1 Patients' characteristics

Number of subject

The total number of the patients was 20. Eleven (five males and six females) were residents at the Grange and nine (six males and three females) were daily commuters from Friern and Claybury hospitals).

Sex composition

Of the day centre and residential patients, eleven were males and nine females.

Age

The mean age is 61.5; median age is 64.5. The youngest person is aged 41 years and the oldest aged 78 years.

Reasons for initial hospital admission

Eight patients were transferred from other hospitals, either general or psychiatric. Six people were mentally disturbed on admission. Three people were admitted because of self-neglect and their inability to cope with life outside the hospital. Two were admitted for forensic reasons, and the one the reason for his admission was unclear.

Primary diagnosis during their stay in hospital

Eighteen patients were diagnosed as schizophrenic, one affective disorder, and one personality disorder.

Total period of previous hospital stay

Median period of stay was 348.5 months; the mean was 331.6. The shortest was 69 months and the longest period of stay in hospital was 645 months, that is to say over 53 years.

Number of previous admissions to hospital

The mean number of previous admissions was 4; the median was 2. Five had no previous admissions. The largest number of admissions was 29 (one person), one person

was admitted 8 times and 3 admitted 3 times. More than half the patients had been admitted to the hospital more than 5 times before moving to the day centre.

It can be concluded that this group of patients largely consists of long-stay patients who would not otherwise manage to live outside hospital. They are a group with numerous admissions to the institution, the majority suffering from schizophrenia.

3.6.2 Comparison between baseline, six months and one year

Physical condition

Two people have restricted mobility (artificial limbs) but they could manage climbing stairs.

Level of care received: Two needed total nursing care to provide basic daily medical and nursing needs (e.g. receiving daily medication, needing to be taken to the bath daily) before discharge and at 6 months and 12 months after their discharge to the community. For two their physical care deteriorated after their discharge and they needed regular but less than daily nursing care, as well as to take daily medication and attend regular appointments with hospital staff and the General Practitioner for conditions such as diabetes, heart and chest disease, arthritis and skin conditions. The physical state of two people improved so that they did not require physical care by the staff. There was no change after one year.

Incontinence: Three people were incontinent before and after their discharge; two were incontinent at the hospital but have not been identified as incontinent in the community. One female became doubly incontinent in the community and started smearing the toilet wall with faeces.

At one year follow-up, two of the nine residents remained incontinent.

Dyskinesias: Three had dyskinesias before discharge and 6 months and one year after their discharge. The remaining 15 people were free from side effects of their medication.

3.6.3 Patients' attitudes toward living outside psychiatric hospitals

The number of patients who answered this questionnaire was 15 at the baseline, 17 at six months and eight at one year.

Reactions towards their discharge to the community

While in hospital three out of eight showed a preference to remain in the hospital and five showed a strong desire to leave. Only one person was ambivalent toward his discharge. Three wanted to leave as soon as possible and two preferred to wait for some time in the hospital before their discharge.

At the baseline, 10 patients out of 15 expressed a strong or qualified desire to leave the hospital, while 4 patients preferred to stay in the hospital and one patient was ambivalent about his discharge.

After six months and one year 10 out of 17 patients indicated that the community residence was better than the hospital. The reasons given were: better food in the community, the atmosphere is better, cleaner and there are more activities, one resident said that he sleeps better in the community than in hospital. After one year six out of eight said that the community was better than in hospital.

Favourable and unfavourable reactions towards residence

From Tables 3.1 and 3.2, patients were more likely to express indifferent reactions towards their living in the hospital rather than to their living in the community. Patients were unlikely to express any unfavourable reactions towards their living in the community.

Table 3.1 Patients' favourable reactions towards their setting at the hospital and in the community

Favourable reactions	Baseline (N=15) (Hospital)		6 months (N=18) (Community)		One year (N=8) (Community)	
	No.	%	No.	%	No.	%
General approval	6	40	3	17	0	0
Staff's company	3	20	3	17	1	13
Patients' company	0	0	4	22	2	25
Amenities	2	13	3	17	4	50
Indifferent	0	0	5	28	0	0
Environment	1	7	1	6	1	13
Independence	0	0	0	0	2	25
Regime	0	0	1	6	0	0
Don't know	0	0	0	0	2	25

Table 3.2 Patients' unfavourable reactions towards their setting at the hospital and in the community

Unfavourable reactions	Baseline (N=15) (Hospital)		6 months (N=18) (Community)		One year (N=8) (Community)	
	No.	%	No.	%	No.	%
General disapproval	2	13	0	0	0	0
Staff's company	0	0	3	17	0	0
Patients' company	2	13	1	11	2	25
Amenities	2	13	0	0	1	12
Indifferent	0	0	2	22	0	0
Environment	5	33	0	0	1	12
Independence	0	0	0	0	0	0
Regime	0	0	0	0	0	0
Don't know	0	0	3	17	0	0

3.6.4 Daytime activities

While in the hospital, 11 people used to participate in hospital activities such as occupational therapy, while the rest had no activities during the day. At six months, 15 had activities at the day centre facilities, five had not attended any form of activities ever, although two of them were residents at the Grange. Only one patient was working in open employment, as a gardener for the Council, while another three were looking forward to having paid jobs in the community.

One year follow-up showed that six out of nine were attending the day centre, while three had no activities organized. Three were attending literacy classes for special groups at the local community centre. After one year one person was intending to work in the printing department of the hospital.

It can be concluded that the majority of this sample of patients were keen to leave the hospital, and were more likely to express positive rather than negative reactions towards their community residence. They were more likely to engage in day-time activities while attending the Grange. These positive reactions were sustained at six months and 12 months in the community.

Difficulties patients faced so far after leaving the hospital

One patient found filling in the DHSS forms and cashing his money from the Post Office to be particularly difficult, and one had complained of the aggressive behaviour of his fellow-resident.

3.6.5 Self-report of overall change

Eleven said that they had felt better since they left the hospital, after six months and after one year. Factors identified as responsible for the improvement in their health were food, outings and one mentioned "time". The number of patients who said that they felt no change in themselves was four after six months and three after one year. There were no reasons given regarding lack of improvement in one's self, except one patient mentioned that sitting around a lot made him bored.

Reactions towards medication

While in hospital nearly everybody considered that taking medication was helpful; only one person said that his medication was very unhelpful and one was indifferent. After six months 12 said that medication was helpful for them, three unhelpful and three did not know. After one year in the community, six patients considered their medication to be helpful, while only one person was indifferent toward his medication.

3.6.6 Patients' social network

Nine patients out of 20 completed the social network schedule on both occasions: five residents and four commuters. The remaining 11 patients were not included in the analysis because they refused to complete the schedule on at least one occasion.

The results showed an increase in the size of the social network for both the residents and the commuters as shown in Table 3.3.

Table 3.3 Size of patients' social network

Patient	Baseline	Six months	One year
R1	1	11	10
R2	13	11	19
R3	4	10	7
R4	10	17	28
R5	2	14	7
C1	5	7	
C2	1	14	
C3	7	14	
C4	3	6	

Key R = resident C = commuter

Residents and commuters at baseline and one year

There was a significant increase in the size of the social network of the residents and the commuters between baseline and six months (t test = 3.965, $p < 0.005$). Estimated mean for the difference between baseline and six months = 6.4. 95% confidence limits for the difference (2,11).

The residents at baseline and six months

T-test on the difference in the size of the social network showed a highly significant difference t-test=2, 750 $p < 0.01$.

Estimated mean for the difference between baseline and six months = 6.6 95% confidence limits for the difference (-0.07, 13.3).

Residents at baseline and one year

T-test on the difference in the size of the social network showed a significant difference t-test=3, 113 $p < 0.05$.

Estimated mean for the difference = 8.2, 95% confidence limits for the difference (0.88, 15.5).

MEAN SIZE OF PATIENTS' SOCIAL NETWORKS

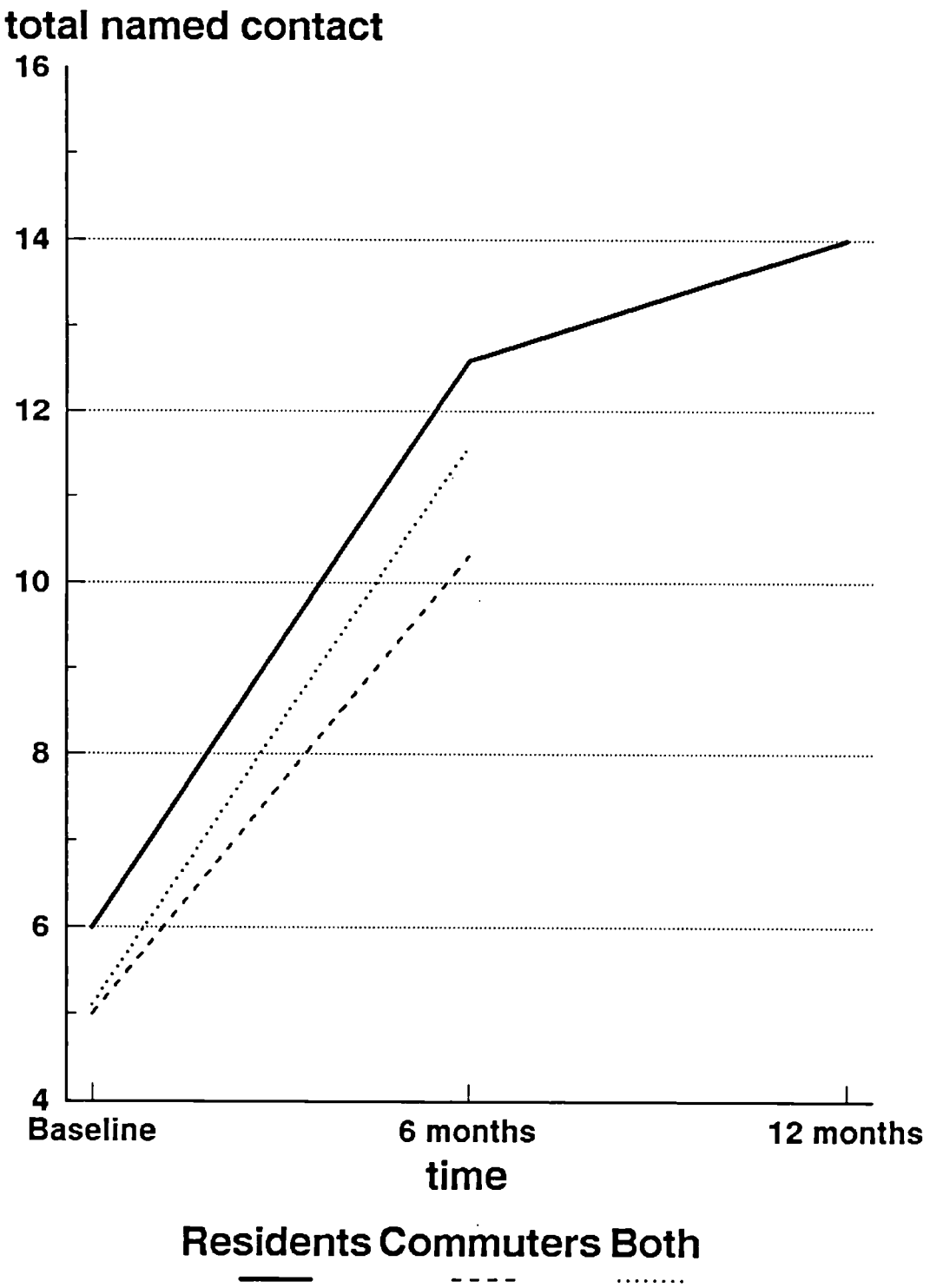


Figure 3.1

Changes in the size of social network from baseline and six months

As shown in figure 3.1 and Table 3.3, the increase in the social networks of the residents and commuters is represented by total number of social contacts seen within a month. There was a significant increase in the number of contacts named as professionals and non-professionals (mainly other patients and relatives). It was found that the number of staff named was relatively higher than the number of contacts named who were non-professional. At six months the staff mentioned worked both in the hospital and the community. At one year follow-up nearly all the staff mentioned were from the community. The number of contacts named as relatives was relatively low in the social networks of both residents and commuters.

Changes in the number of professionals

There was a significant increase in the number of professional contacts between baseline and 6 months. The professionals named were those working in the community and at the hospital. T-test=4.00 $p < 0.05$. Estimated mean for the difference between baseline and six months = 4. 95% confidence limits for the difference (1, 7, 6, 3).

Changes in the number of non-professionals

There was an increase in the number of non-professional contacts between baseline and six months. The non-professionals named were those attending the day centre from both hospitals. There was no significant increase in the number of relatives or non-professionals.

Changes in the quality of patients' social network from the baseline to six months

The contacts named as friends were more likely to be among non-professional rather than professional contacts. However, the number of staff mentioned as friends was higher among the residents than the commuters.

Changes in the number of professionals considered as friends

There was a significant increase in the number of professional contacts seen as friends between baseline and six months.

T-test=3.623 $p < 0.01$. Estimated mean for the difference between baseline and six months = 5. 95% confidence limits for the difference (1.9, 8.5).

Changes in the number of non-professionals considered as friends

There was a significant increase in the number of non-professional contacts seen as friends between baseline and six months. T-test=3.647 $p < 0.01$. Estimated mean for the difference between baseline and six months = 3. 95% confidence limits for the difference (1, 9, 8, 5).

Changes in the number considered as confidant

There was a significant increase in the number of non-professional contacts seen as confidant between baseline and six months.

T-test=3.333 $p < 0.02$. Estimated mean for the difference between baseline and six months = 4. 95% confidence limits for the difference (1.3, 7.1).

It can be concluded that there was a significant increase in the size and the quality of the social networks for both the residents and commuters after six months and one year. This increase was mainly in the number of professional contacts. While at six months the number of professionals named was a combination of the staff at the hospital and the staff at the community residence, at one year the professionals named by patients were only those at the community residence. It was interesting to note that not one of the neighbours was mentioned in the social network by the residents even after one year of living in the community.

3.6.7 Patients' social behaviour

Patient's social behaviour showed significant difference in the areas of personal hygiene, and ability to initiate interaction. There was a tendency towards improvement over time, especially in the areas of underactivity, and ability to make social contacts. Areas of social behaviour that showed no change over time are posturing and mannerisms, oddity of conversation, overactivity, laughing and talking to oneself and slowness. Whereas areas that showed non-significant deterioration are socially unacceptable behaviour and hostility. Anxiety showed a near-significant increase over time ($p = < 0.054$). Repeated measure t-test showed no significant changes for other aspects of social behaviour over time.

Table 3.4 Patients' Social Behaviour Problems at Baseline and 6 months

Social Behaviour	Baseline (N=20)		6 months (N=20)		
	No.	%	No.	%	
Hygiene	16	80*	7	35*	p<0.01
Initiate conversation	13	65*	5	25*	p<0.01
Ability to make social contacts	10	50	9	45	
Underactivity	8	40	7	35	
Hostility	7	35	3	15	
Oddity of conversation	6	30	8	40	
Socially unacceptable habits	6	30	7	35	
Laughing/talking to self	5	25	3	15	
Concentration	5	25	1	5	
Slowness	5	25	2	10	
Attention seeking	4	20	3	15	
Posturing & mannerisms	4	20	6	30	
Depression	3	15	5	25	
Coherence of conversation	3	15	6	30	
Panic attacks/phobias	2	10*	7	35*	p<0.05
Acting out bizarre ideas	2	10*	6	30*	
Overactive	2	10*	4	20*	
Suicidal ideas/self harm	1	5	0	0	
Violent/threatening behaviour	0	0	0	0	
Inappropriate sexual behaviour	0	0	1	5	

(* behaviour showed greatest changes).

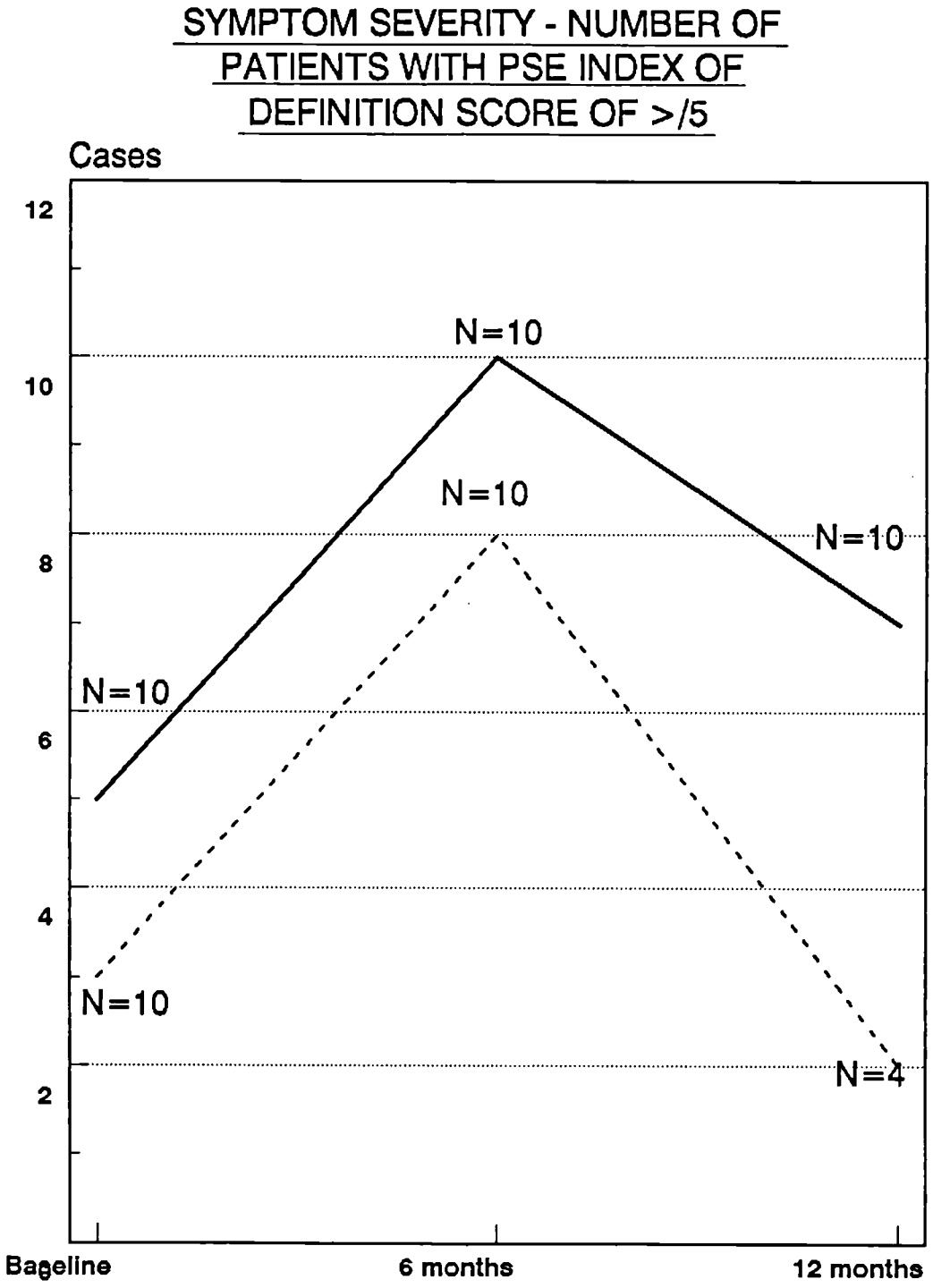

SYMPTOM SEVERITY - NUMBER OF PATIENTS WITH PSE INDEX OF DEFINITION SCORE OF >/5
Cases
12
10
8
6
4
2
N=10
N=10
N=10
N=10
N=10
N=4
Baseline
6 months
12 months
Residents
Commuters

Figure 3.2

3.6.8 Patients' clinical condition:

Patients' mental state was monitored in the community by regular visits from the community psychiatrist to the residential patients. He met regularly with the key workers. Apart from these regular visits, patients visited their GP for urgent needs.

Patients' Symptom Profile on PSE

The four groups of PSE syndromes were analysed and showed no change in patients' general or specific neurotic syndromes over time, while delusions and hallucinations as well as behaviour, speech and other syndromes showed some changes.

Delusions and hallucinations

There are 10 PSE syndromes which include all the items relating to delusions and hallucinations. The DHA score was compared across the three occasions of ratings. The scores on each syndrome are summed to produce a total DHA score. The results of this analysis showed that the residents were more likely to express delusions and hallucinations in the community than the commuters (p=0.075) (Table 3.5 and 3.6). Four patients developed delusional ideas and hallucinations after six months in the community. Disturbances in perception showed no significant improvement after one year, nor did non-specific neurotic syndromes.

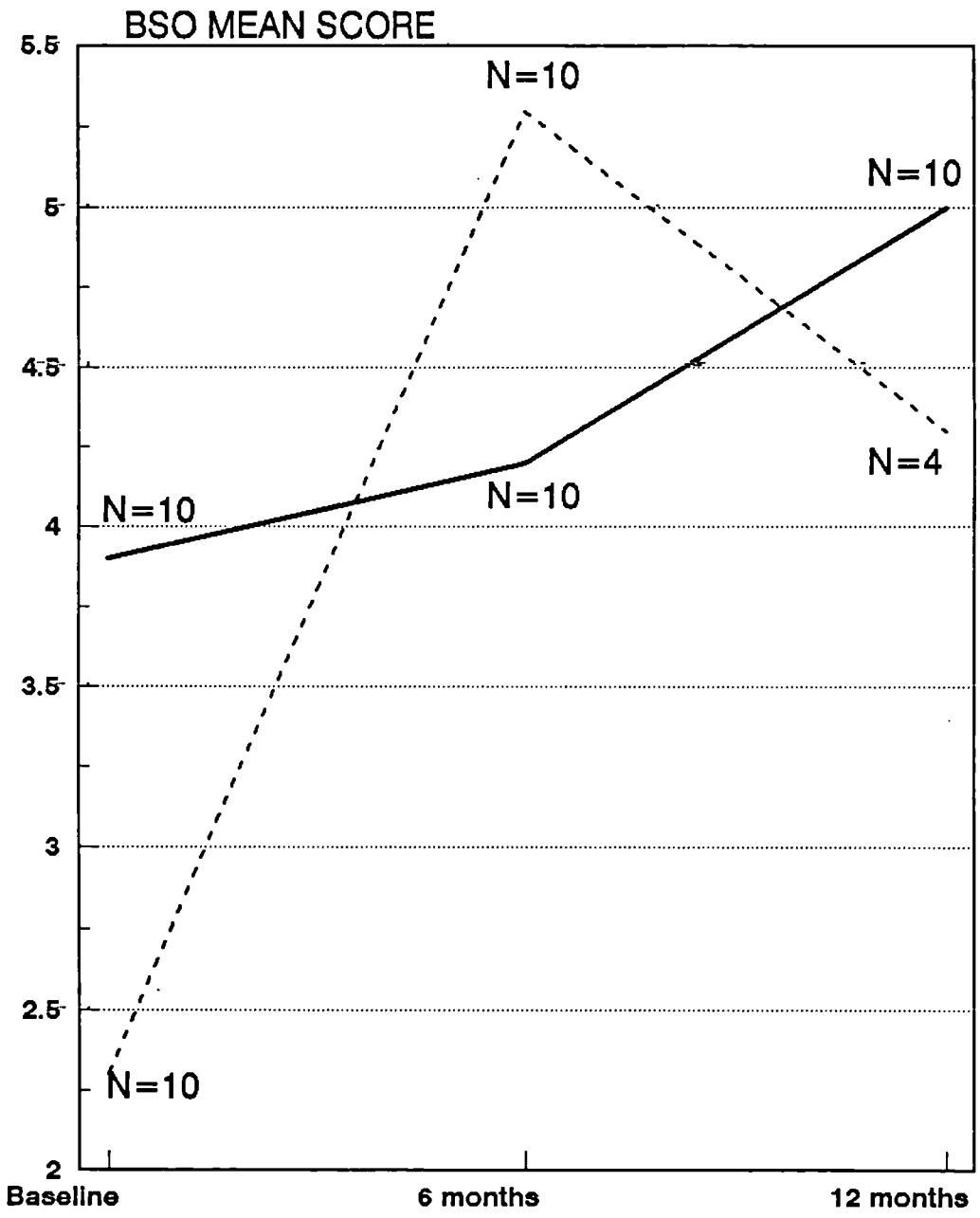
Table 3.5 Delusions and Hallucinations among the Residents

Time of interview	Presence of DAH
Baseline (10)	2
6 months (10)	6
One year (10)	6

Table 3.6 Delusions and Hallucinations among Commuters

Time of interview	Presence of DAH
Baseline (10)	3
6 months (10)	3
One year (6)	2

BEHAVIOUR, SPEECH AND OTHER SYNDROME(BSO)
BASELINE, 6 MONTHS AND 12 MONTHS



Residents Commuters

Figure 3.3

3.6.9 Behaviour, Speech and Other Syndrome (BSO)

Similarly the BSO score showed a significant deterioration at 6 months (figure 3.3) (T=2.96, p=0.0081). Analysis of the observed behaviours that make up the BSO score showed a trend towards improvement in patients' self neglect, but slight deterioration over 6 months in observed anxiety and depression. Then slight improvement after one year especially in the area of bizarre behaviour and restricted quantity of speech.

Number of Cases: Baseline, 6 Months and One Year

As shown in figure 3.4 the Present State Examination (PSE) data showed a significant difference over time with respect to the severity of symptoms. It was found that the Index of Definition (ID) level rose significantly between baseline and 6 months (t=4.234, p=0.004) as shown in figure 3.4. Summary statistics for time by ID DF=12.584 ($p<0.001$) showed a high degree of significance which indicates deterioration in the mental state of all 20 patients in the community. This deterioration was greater at six months than at one year.

3.6.10 Environment

Assessment of the environmental setting in the hospital and in the community regarding restrictive practices and individual autonomy, includes activities, patient's possessions, patients' rooms, services and social atmosphere. The results showed that there was improvement in all of these areas. The average total score on all aspects of the environment in the hospital was 29.00, range (0-4) that is to say, a restrictive environment. By contrast the environment of the community facilities is permissive: the average total score was less than half the hospital score: 13.70.

Repeated measures t test was highly significant (t=5.60 p=0.001). The permissive environment persisted at 12 months.

One could conclude that the majority of patients felt satisfaction towards their discharge to the community. Patients noticed changes for the better in themselves since leaving hospital, their life style, social network, social behaviour, hygiene and day time activities showed great improvement. However, their mental state showed some deterioration.

3.7 DISCUSSION

The most striking feature of the results is the differences in patients' clinical state and social networks after 6 and 12 months living in the community and that the majority expressed positive attitudes towards community living. In this section the results will be discussed under the following headings: a.methodological critique of the study b. patients' mental state, c patients' social networks; d. patient's quality of life d. patients' attitudes towards community living.

3.7.1 Methodological Critique of the Study.

A small number of patients was investigated, this being dictated by studying a single community mental health facility. This small sample was further reduced by a split between residents and commuters. However, it was possible to set the findings in the context of a large sample from the TAPS study, which included more than 1100 patients.

Even though there was no control group at 6 months follow-up, there was a control group available for one year follow-up. Subjects were not randomly selected, but were chosen by staff to move to the Grange or to attend there daily. These patients may have been selected for better outcome.

A major shortcoming in internal validity is the lack of adequate description of what comprises the nature of care received, the degree of staffing and the arrangements for patients discharge for Friern and Claybury hospitals in comparison to the Grange. Other shortcomings in this study are: 1. inability to complete the observational study due to staff anxieties; 2. Lack of blindness of the researcher in assessing outcomes and 3. inability to generalise the findings from a single unusually large community facility to the average community home.

In this study a broad spectrum of tools were used to assess various aspect of patient's needs in the community, however, the quality of patients' life was difficult to assess as each person has his own set of values.

3.7.2 Patients' Mental State:

Analysis of the results showed that the patients were more likely to express delusions and hallucinations in the community than when they were in the hospital. Deterioration occurred in the observed behaviour score, especially observed anxiety and depression. Significant differences in respect of severity of symptoms were found for all 20 patients. This is evidence that the transition was stressful in that it affected patients' mental state. This suggests that more psychological support is needed during this period. The discharging of long-stay patients after a long period of institutionalisation has been shown to have a disturbing effects on their mental state. Similar results were obtained by the Team for the Assessment of Psychiatric Services (TAPS) from a one year's follow up for a similar sample (TAPS reports 1989). However, Wingerter (1982) and Goldstein & Caton (1983) indicated that patients with extensive histories of hospitalization showed no difference in their mental condition after discharge as opposed to patients with a relatively short period. Kingdon (1991) followed up 18 patients in the community and found that after 12-24 months patients showed reductions in their symptoms and expressed satisfaction with their present accommodation.

As expected the results of the social behaviour scale showed a near significant increase in patients' anxiety after 6 months. Similar results were obtained by Bachrach (1984) who indicated that these high levels of anxiety may be maintained in the community

for as long as 15 months. These results suggest the great need for medical and nursing attention immediately after discharge or the need for a gradual discharge plan.

3.7.3 Patient's Social Networks

On the positive side, patients' social networks showed a significant increase at 6 and 12 months, mainly due to professional contacts. These results rejected the null hypothesis that patients' social network outside psychiatric hospitals is decreased. One could speculate that the reasons for the significant increase are: the Grange is a 24 hours staffed setting, patients were still remembering hospital staff at the time of the interviews and some hospital staff kept some contact with the patients by inviting them to the Christmas party at their wards or sending birthday cards.

None of the local residents were included in patients' social networks. Perhaps 12 months was not long enough for former patients to form relationships with their neighbours, or, as observed, the staff were overprotecting the patients and devoting little effort to introduce patients to their local community, or possibly local residents avoided contact with them. Griffiths (1974) and Glazer et al (1982) found that social isolation was due to frequent hospitalization. Schooler (1963) indicated that schizophrenic patients were more reluctant to expose themselves socially than normals and that the length of hospitalisation affected their willing to socialize, especially the male patients.

3.7.4 Patient's Quality of life:

Deinstitutionalization has more recently come under criticism from a number of disciplines as patient's quality of life was one of the main issues discussed by various professionals. Some studies identified 'Quality of Life' as the critical outcome variable for evaluating community services for the chronic mentally ill. This study showed that patients' quality of life improved in the community, based on data from both patients and staff members. The results showed patients' satisfaction with the significant increase in permissiveness of their physical environment.

Very little evidence suggest that the staff were relaying on objective information regarding evaluating daily programme of care. The programme of activities in the day centre included making jewellery, photography and tie dying, which were what the staff knew and what were available in the community rather than what patients could do or wanted to do.

The results suggested specific changes that could improve patients' quality of life in the future in services such as providing suitable jobs and daily activities. One should bear in mind that the level of impairment of patients undoubtedly affected the quality of the living environment. It appears that the widespread concern that many chronically mentally ill people in the community were socially isolated is in conflict with the present results.

Although it was the number of staff that increased the size of the patients' networks, one could say that this increase is a positive aspect during the transition period.

3.7.5 Patient's Attitudes Toward Community Living:

This study showed that patients expressed positive attitudes towards community living, especially food and the physical environment. Similarly of the TAPS patients who had left in the first 3 years to live in sheltered accommodation, the great majority preferred their new homes and were happy to leave the hospital (TAPS, 1990). Contrarily, Weinstein (1979) in his study of patients' attitudes towards living preference indicated that patients showed more favourable attitudes towards hospitalization than the community. Goldman (1965) explained the positive attitudes towards hospitalization as opposed to community care on the basis that the patient might be attracted to the hospital because of anxiety about leaving. He found that living preference appears to be a strong predictor of both re-hospitalisation and amount of time spent in the community. There was a strong relation between hospital preference and hospital tenure, which did not seem to be affected by past hospitalization.

One could argue that the previous researchers examined the attitudes of in-patients. They also were not specific about the reason for hospital attraction. Staff members at both the hospital and the Grange were positively encouraging the patient to make the transition as part of the hospital policy or as part of the staff's positive attitudes toward community care.

The official criteria for selection were the patient's willingness to move to the Grange, medium dependency, lacking aggressive behaviour, and ability to climb the stairs. One could expect that these are partly the implicit criteria of public acceptability.
In all the visits the patients were brought to the Grange by their staff members driven in a Haringey Council van. Previous studies showed that using an ambulance for transferring patients could intensify the stigma of mental illness. Certainly this practice does not conform to the principles of normalisation. Many of the local residents expressed fears about the presence of former psychiatric patients in their neighbourhood. Perhaps trying some strategy for reducing the effects of the stigma by not attending the day centre by Haringey Council van would have avoided making them stand out as visibly different.

It is understandable that patients might experience some disappointment or depression after the initial move into the community. The feeling of loss or depression could mistakenly be seen as part of patients' illness rather than a normal grieving process. This problem of the transition period requires experienced staff to deal with grieving. The staff at the Grange encountered patients' problems such as lack of motivation, boredom, or negativism. They failed to see this as a matter of settling in and learning to live in a group within a home like environment, or as a pathological problem of chronic schizophrenia. For example one of the patients expressed her anxiety by regressed

behaviour, smearing the toilet walls with faeces. The staff considered the patient unsuitable for resettlement while the hospital staff accepted the behaviour as part of her anxiety toward her discharge, consequently friction developed.

Therefore one should examine the processes that translate various types of reactions into greater or less social integration for former psychiatric patients in different settings.

4. STAFF STUDY

4. STAFF PERCEPTION OF THEIR ROLES OUTSIDE PSYCHIATRIC HOSPITALS

INTRODUCTION

In this study staff roles were considered crucial during the transition period. It has been assumed that staff with experience of working with former psychiatric patients and with positive attitudes towards community care might influence public perception of mentally ill people.

In this section, the following items will be discussed:

1. Staff roles outside psychiatric hospitals
2. Staff preparation for their roles before working outside psychiatric hospitals
3. Staff attitudes toward working outside psychiatric hospitals
4. Various programmes of care implemented in the community
5. Rehabilitation

4.1 STAFF ROLES OUTSIDE PSYCHIATRIC HOSPITALS

The transition to community-based psychiatric health services has highlighted more than ever the importance of the staffing resources. The new pattern of care and its delivery means new roles for the current staff. However, little research has been carried out to identify staff reactions to the process of transition from hospital based to community based services and their needs for programmes of preparation as well as their contribution to the success of the transition of the services.

The House of Commons Social Services Committee (1987) debated whether community nurses or social workers are the most suitable people to take a case manager role. There has been a general view that nurses should start preparing themselves for a case manager role in community care. However, Bernadat (1990) pointed out that social workers, home care managers and community nurses are not equipped to assess complex symptoms including concurrent physical illness. She argued that the case manager should be a member of the multidisciplinary team who has specialist skills, and would not duplicate the efforts of other members.

Shaw et al (1990) described the role of case manager as: assessment of patient's needs, planning services, linking patients to services, monitoring them to identify changes in needs, and speaking on their behalf with services agencies. These researchers assessed case managers' activities as they were described in 286 patients' records from three different community treatment systems. They found that in most instances case manager work was associated with better community care. The longer the duration of contact with the client, the greater was the range of case management activity. Shaw et al (1990)

recommended that case manager work should continue indefinitely for severely and persistently mentally ill people.

There were two main roles identified during the transition of the services:

1. Preparing psychiatric patients upon their discharge:

During the transition period staff members encountered a population of patients characterised by apathy, lack of initiative, and social isolation. The majority of psychiatric patients had lost all contacts with their immediate relatives and looked upon the hospital as their home, according to a Friern survey of 1985.

The Royal College of Psychiatrists (1989) recommended a number of discharge and after care procedures for patients. These were: at the hospital the multidisciplinary team should be involved in individual patient's plan of care. The concept of the key worker should be practised. The consultant should take overall responsibility for the organisation of patient care. A case conference should be held following patient admission to the hospital to decide upon diagnosis, medication and other therapy. At time of discharge, each patient whose discharge was considered would be discussed at a multidisciplinary ward team meeting or case conference. A full assessment should be conducted of the patient's physical, mental and social requirements. Patient's needs and measures to be taken should be itemised. The services needed for continuing health care should be carefully considered e.g. allocation to the G.P., out-patient psychiatric appointment, trial leave, review meetings, social services support, accommodation, sheltered workshops. daytime activities, and family support.

Nurses should take a central role in the multidisciplinary team, and one would expect their job descriptions to change by clarifying the practical implications of the philosophy of patient care in the community, for example the balance between staff helping the patients and encouraging patients' autonomy.

Upon patients' discharge they will lack the supportive structure of the hospital as well as having poor social networks. Therefore, one would expect that patients' social behaviour and the development of their social networks would take priority in rehabilitation efforts.

Failure of the staff to recognise some patients needs for structured routine, might contribute to their repeated rehospitalization (Lamb (1984). Bachrach (1984) discussed nine principles of service planning for chronic patients undergoing deinstitutionalization. These principles were: identifying precise goals and objectives, identifying priorities in service delivery, re-assessing institutional services, organising service interventions, obtain inter-agency co-operation, designing individualised programmes of care, designing culturally relevant programmes, using flexible programme formats, and exercising caution and restraint.

2. Encourage patients integeration into their local community:

In Britain, large-scale community mental reprovisions for the mentally ill emphasis on the principle of normalisation. This led to employing staff with domestic skills rather than with academic skills. Consequently no attention are given to involve the local community in the life of community mental health reprovisions.

Bachrach (1980) suggested that a successful programme for chronic mental patients is characterised by:

1. Being targeted on patient's needs.
2. Being linked with other resources in the community.
3. Providing a full range of functions to cover patient's needs.
4. Individually tailored treatment.

Staff also play a crucial role in relation to patients' families during the transition period. Lau (1990) studied the patients families' reactions towards closing Cane Hill Hospital. The results of 23 mailed questionnaires showed that:

1. About half the respondents (9)accepted the decision to close the hospital, 8 disagreed and 6 were not sure.
2. Relatives who agreed with the policy thought that the community might provide better care than the hospitals and could enable them to visit more often.
3. Relatives who disagreed claimed that community care was introduced only to save money. They were worried about their relatives' quality of care in the community.

Those who were unsure were worried about the staffing levels and patients' accommodation in the community. Patients' relatives were pleased to have smaller units as an alternative to hospitals. When patients' families were asked where they would like their relatives to be placed in the community, none wished to have their relatives to live with them, 19 out of 23 preferred them to live nearby and only 3 wanted their relatives to live far away from them. The reasons identified for not wanting to have their mentally ill relatives living with them were: they were too old to look after them and the professionals would provide better care than they could. More than 2/3 (19) said they would like to be consulted about their relative's resettlement in the community, to be informed about their relative's support group, as well as financial and work arrangement for their relatives. Out of 19, 6 families wanted to be involved in the preparation process.

Even though some relatives might take part in patients' resettlement plans nurses would continue to carry the major responsibility. Bulmer (1986) examined different relationships of kin, neighbours and friends. He demonstrated that in a short-term crisis, reliance was on general support of friends and neighbours, while long-term care was restricted to kin relationships, and care in the community provided by paid workers.

3. Patient's Rehabilitation

Introduction of the key worker system, the nursing process and more general skills training is essential for individualised rehabilitation programmes. Staff and patients on the wards should be able to discuss, evaluate and adapt the proposed design and operational polices of the future district services.

Rehabilitation services should begin by presenting a set of tasks for the staff with expertise in assessment, resettlement and rehabilitation, which is different from the tasks carried out in large hospitals. Research in psychiatric rehabilitation has suggested that psychiatric patients could be taught a wide range of physical, emotional and intellectual skills. For example, Anthony and Margules (1974) considered that skill training with specific objectives and specific techniques can improve skill levels, regardless of patients' symptomatology. Vitalo and Ross (1979) reported that patients in a skill training group experienced symptomatic relief equivalent to that of a control group of patients on medication only. Bachrach (1980) emphasized that rehabilitation must serve all patients even those who showed little hope of improvement.

Steinhart and Bosch (1990) carried out studies of patients admitted to rehabilitation homes after a long hospitalisation. The finding revealed that 3/5 of them had been able to live in their own flats with staff support, 1/5 were in intensively staffed homes where the patients function was optimal, while 1/5 had to return to the hospital for a long admission. Increasing self-esteem and personal autonomy, assertiveness and good social skills were associated with a better outcome.

Models of rehabilitation:

In this section description of some models used in the preparation of chronic psychiatric patients will be discussed:

1. Medical model: looks at patient's diagnosis in terms of his symptoms, and treats the symptoms by physical means. Its advantages are that some symptoms can be controlled by medication. However, its disadvantages are that it allows the patient to fall into the sick role, ignores the effects of the patient's environment and may continue to stigmatises the person.
2. Skills model: adopts a behavioural approach to teach patient's lost skills to restore his functioning. The model stresses the importance of teaching skills in the environment in which the patient is going to be based.
3. Behavioural model: uses a behavioural approach as a means of building skills and changing behaviour. It focuses on adaptive rather than maladaptive functioning and the relationships between behaviour and environment.
4. Wing's handicap model: suggests three levels of handicap which people with long-term psychiatric disability experience:-

a. Primary handicaps (intrinsic): psychiatric symptoms, active or very vulnerable to relapse. Wing included "negative symptomatology" such as social withdrawal, poor motivation and lack of appropriate affect.

b. Secondary handicaps: adverse personal reactions to disability- poor cooping strategies, loss of confidence, loss of social roles, adoption of the "sick" and "patient" roles.

c. Tertiary or extrinsic handicaps: disadvantages which are to some extent independent of the illness, such as poor education, low I.Q., and difficult family life.

5. Normalisation: 'implies, as much as possible, the use of culturally valued means in order to enable, establish, and/or maintain valued social roles for people' Wolfensberger (1972).

Normalization has recently been called "social role valorization" that is to say " the creation, support, and defence of valued social roles for people who are at risk of social devaluation" Wolfensberger (1982). Normalisation principles dictate the use of ways, means and methods which are valued to develop and support personal behaviour, experiences and characteristics which are valued by society.

Normalisation has been misunderstood by some carers as putting long-stay psychiatric patients into "normal" settings away from the hospital so that they would became "normal". They ignored patients' problems and disabilities which needed to be treated. Some carers became very concerned with the size or appearance of the facilities and neglected meeting the patients' needs. Normalisation has the disadvantage of ignoring a possible need for asylum.

Some staff tend to use slogans and catchwords or a superficial reference to ideology in their activities in community facilities such as normalisation. The problem is to achieve a balance between the values implicit in normalisation or any other intervention and what is best for psychiatric patients. Staff recognition of the value of their intervention to support patients in the community is important, as for example the balance between the principle of normalisation and proper assessment of patient's needs.

6. Social rehabilitation programme:

Psychological rehabilitation is based on rehabilitation theory and social work approach. The programme focuses on helping patients to acquire practical living skills. This includes: learning appropriate and social behaviour in a normalisation environment and reducing behaviour which leads to regression and rehospitalization. The educational approach of social rehabilitation programmes has the value of increasing self esteem by giving the patient the message that the staff believe in his capability to understand and learn. Components of the social rehabilitation programme are: community survival skills, health education, work skills, basic education skills.

Specific training skills:

1. Community survival skills: provide the practical knowledge that will increase the

ability of the chronic psychiatric patient to live in a community sitting. Therefore, the focuses on teaching the patient how to plan a meal, shopping, cooking, using public transport, budgeting and dealing with various agencies.

2. Health education: provides the patient with information about physical diseases, nutrition and the nature of mental illness.
3. Education about medication: teaches the patient how to manage his medication.
4. Preparation for work: improves attitudes to work.
5. Psychoeducation for chronic psychiatric patients consists of family therapy, social rehabilitation and self-help groups.

There has been stress in recent years on the importance of patients' social skills and problem-solving capacities. The essential principles of psychiatric rehabilitation are:

1. Improving psychiatric patient's capabilities and competence.
2. Improving the patient's ability to do things despite the presence of residual disability.
3. Psychiatric rehabilitation is eclectic in the use of a variety of theories and models.
4. Psychiatric rehabilitation focuses on improving the patient's vocational skills.
5. Positive expectation and hope are essential for psychiatric rehabilitation.
6. Accepting temporary dependence as it might lead to an eventual increase in the patient's independence.
7. Active participation and involvement of the patient in their rehabilitation.
8. The fundamental psychiatric interventions are skills development and environmental resources development.

It can be concluded that the staff roles in the patient rehabilitation programmes before and after hospital closure is paramount. Various programmes for patients to facilitate their reintegration into the community were presented. Little attention was given to the staff needs in order to work in the community.

4.2 STAFF PREPARATION BEFORE WORKING OUTSIDE PSYCHIATRIC HOSPITALS

The Second Report of the Social Services Department Committee (1985) as well as the Griffiths's Report (1988) stressed the importance of staff training during the period of implementation of community care, especially for informal carers and unqualified social services staff in order to carry out their role effectively. He recommended a training programme which should start with a full assessment of the training implications of all groups concerned.

Davidson (1990) argued against the current trend of staff training to meet immediate needs rather than adopting a broader educational approach. He considered that

training and orientation programmes are lagging behind the need for a shift in hospital care. Staff are relying on their experience in hospital, common sense and on private study and attendance at seminars etc. He suggested that staff training should start by a change in staff attitudes towards personal growth, career development and client/worker relationships, and the needs of staff in the new services. He pointed out that the emphasis of the White Paper 'Caring for People' on the immediate need to teach social workers assessment and mechanics of legislation might ignore the importance of teaching skills and attitudes based on education.

One would expect staff training to include experience in health related sciences, and additionally, psychosocial rehabilitation (or tertiary prevention). In an attempt to prevent or reduce worsening of the patients, community facilities such as sheltered workshops and halfway houses were developed to assist patients' adjustment in the community. There is a need to understand the nature of psychiatric symptoms and disabilities in relocating mental patients in the community.

Echlin et al (1990) emphasised the following regarding staff training during the transition of care:

1. Training that involves relevant statutory agencies, voluntary organisations and user groups.
2. A strategy that leads to an inter-agency and inter-disciplinary approach
3. Training that is based on both the needs of the services and the need for personal development of individual staff.
4. Training that has a clear value which reflects the way the services work and the way the staff have been trained to work with users.

There has been some thought given to an a appropriate framework for future planning of psychiatric nursing training. Polcin (1990) designed a model for patient and staff relocation and rehabilitation before their move to the new district services. The step by step model was: 1. Establishing communication within the hospital and between it and the district. 2. Allocation of patients to districts. 3. Investigating the physical alternatives of the facilities. 4. Investigating the proposal for local services by identifying liaison staff and arranging for district visits. 5. Consultation with the staff about preferences on relocation. 6. Identification of wards to be given priority for transfer and the period in which they would move.

Accordingly, some staff who have been working with the patients in the priority wards would be chosen for the jobs while others would move to long-stay wards.
Although a certain amount of assessment and preparation work would be carried out before the transfer, the bulk of the intensive rehabilitation and training efforts would take place after the transfer. Both patients and staff should be provided with intensive support at that time. Day to day experience would indicate further adjustments to the staff and

changes in the care plans for individual patients as some patients might prove less dependent or independent than it was originally thought.

The resettlement team/rehabilitation teams' major role in the transition process would require an appropriate level of staffing and resources. The staff should discuss their feelings about their transfer e.g.. hopes and fears for the future. Their task on the ward would match those in the new services. Detailed assessments and planning should be focused on individuals and small groups of patients. Staff need psychological as well as professional support. Isolation of professional groups can lead to failure of communication and a consequent inability to recognise their needs and the options required to meet those needs.

4.3 STAFF ATTITUDES TOWARDS WORKING OUTSIDE PSYCHIATRIC HOSPITAL

Staff responses to changes in working conditions either way could enhance or delay the progress in introducing innovations within the psychiatric care system. Positive attitudes and acceptance by the staff of changes in mental health care delivery are essential for those changes to be effective.

Working outside the hospital requires staff who possess skills and motivation. Staff support in the community is essential to ensure that motivation is maintained. Poor personal support could lead to burnout or loss of morale. Shearer (1983) indicated that a helpful colleague, subordinate or supervisor, and successful communication were two equally important factors in providing good personal support for the staff. She added that well-supported staff are characterised by their ability to set standards, work hard, take action whenever necessary, give their opinion, share problems, and be inventive. Communication is essential for staff support. Shearer (1983) suggested that managers are more liable to isolation than other members of staff. She added that the usefulness of staff meetings depends on the interpersonal skills and competence of staff who run them.

Blum and Downing (1964) studied staff responses to innovation in a mental health service to identify what needed to be anticipated and under what conditions the staff were likely to react. They also studied how changes could be introduced so as to minimise resistance, and in case resistance occurred, the best way to deal with it. Several measures were employed to observe staff responses. The researchers also studied records of complaints and the turnover rate as well as records of activity and efficiency. A questionnaire was used with all staff members shortly after plans for change had been announced and then once again one year after the new programmes were implemented. The results showed that termination of work contracts were most frequent in the services that experienced the most forcibly imposed change. Blum and Downing (1964) explained the phenomenon as due to some staff feeling under threat and becoming distrustful.

Factors that led to resistance were threats to the autonomy of services to the extent to which changes in the work occurred. Resistance continued once it had started even though the intensity of feelings diminished. They concluded that the way to introduce change is to set up entirely separate units, or to allow existing units to put programmes into operation according to their own ideas, or perhaps to wait until services could be persuaded of the need for change so that they could derive motivation from their own convictions.

Davidson (1990) suggested two approaches to change staff attitudes:

1. Training and education should be interdisciplinary, involving all mental health professionals, users, carers and volunteers to break down stereotypes and prejudices, and to form networks across disciplines using communication free from jargon.
2. Training should be safe and participatory, encouraging all opinions and viewpoints.

While policy decisions may be forced through in the face of staff resistance to change, lack of attention to staff attitudes will undermine the success of community care. Parish (1990) advised that NHS managers should involve the staff in their organisational changes because inappropriate decisions would be a waste of human resources. There is a wide gap between the theory of change and implementation by NHS managers.
Blum and Davidson (1964) pointed out that giving into staff pressure by allowing local autonomy does not guarantee goal achievement, but adequate resources and supervision must be provided.

The effects of the working environment on staff attitudes should be taken into account in staff preparation programmes. Slimmer et al (1990) studied the effect of psychiatric clinical learning on nursing students' attitudes toward mental illness and psychiatric nursing. The tools of the study used before and after their clinical training were: Environmental Rating Scale, an Attitudes Toward Mental Illness Scale, and an Attitude Toward Psychiatric Nursing Scale. The study sample was 45 university nursing students. The results indicated that clinical training did not affect students' attitudes toward mental illness. However, there was a significant correlation between a decrease in authoritative, restrictive attitudes toward mental illness and an increase in milieu therapy and community mental health orientations to psychiatric nursing.

Very little attention has been given to the interaction between patients and staff. Flece et al (1986) and Saxby et al (1988) showed that patients' activities positively correlated with staff-patient interaction as well as patient-staff ratio.

4.4 CHARACTERISTICS OF PROGRAMMES OF COMMUNITY CARE

The successful resettlement of patients from hospital to community-based care has been a central principal of government philosophy for the past thirty years. The recent initiative is embodied in the "Care in the Community" documents of 1983 and 1985 . These propose the concept of patient care within the local community away from large psychiatric hospitals. In July 1983 the North East Thames Regional Health Authority made the decision to close Friern and Claybury Hospitals and transfer the patients there to district based services.

These two hospitals are to be closed in an attempt to:

a. Test the feasibility of providing extra-hospital care for the patients in the community,

b. Identify the characteristics of effective services,

c. Provide models for planning services in other regions.

Studies on deinstitutionalization have used a few criteria by which to assess success or failure of providing psychiatric services outside psychiatric hospitals. The following criteria were identified from the literature on community care: social integration of former psychiatric patients (Segal and Aviram, 1978), recidivism (Steadman, 1981), the success of community facilities in keeping patients out of hospital, type of community facility Reusch and Brodsky, (1968), social integration (Segal and Aviram, 1978), providing basic living needs, and insulating society from deviant behaviour (Stein and Test, 1978).

These are some important features of patients' programme in the community:

1. Promotes social integration of former patients:

The literature on community care stresses the importance of former patients' integration in their local neighbourhood to ensure a successful outcome. Segal and Aviram (1980) assessed the social integration of mentally ill people in sheltered care facilities in the State of California. The research concentrated on factors that helped or hindered the social integration of sheltered care residents, both within the facility and in the external community. They used structured interviews to measure the degree of an individual's integration. Staff members and the residents answered the same interview about the social nature of their environment, neighbourhood reaction, level of psychopathology, and degree of satisfaction with the living environment. Staff members were asked about their role and the reception of this role by the neighbourhood. They were also asked about their relationships with the residents, and about the social and medical services available in the community. Most of the patients were not much trouble to the community, since they had mild levels of psychological and emotional disorders.

However, patients had not made a full transition to the community since none of them had been employed.

The researchers developed criteria for both internal and external integration to measure levels of involvement. Criteria used to measure external integration were:

a. Being present in the community and participating in activities such as shopping
b. Having access to community resources
c. Having access to basic and personal resources
d. Having access to and participating in family life
e. Having access to and participating in friendship
f. Participating in community groups and using community recreational facilities

In addition, they developed elements that could increase internal integration, and criteria for internal integration.

2. Promotes patient's autonomy:

Segal and Aviram (1980) concluded from their study that it was important for former psychiatric patients who do not exhibit psychiatric symptoms to choose their own placement and to live close to community resources. External and internal criteria for integration showed little or no significance for former psychiatric patients who exhibited moderate or severe psychiatric disorders. The most important factors for these patients were sufficient finance and whether neighbours reached out to them.

3. Activities involved in the programme of care:

Segal and Moyles (1979) studied two different styles of management of sheltered facilities. One was structured and the other one was unstructured. Residents of structured environments were more dependent in decision making than residents of unstructured environments.

Segal and Baumohl (1980) indicated that the social integration of former psychiatric patients in sheltered accommodation was influenced by the unique and complex interaction between community, facility and residents' characteristics. They stressed the need to find the right environment.

A few studies investigated the effects of community facilities on patients' adjustment in the community. Segal et al (1989) interviewed 397 residents of 211 sheltered-care facilities using a cluster design. They employed face-to-face structured interviews with the residents and staff members in order to investigate how they used their local area and how the individual's characteristics affected their integration. The results showed that social norms determine former patient's progress according to the type of care received within the sheltered accommodation. The most progress occurred in accommodation in which staff members allowed for patients' independent outreach, and also where patients shared their personal characteristics with the dominant social group, or the dominant group was able to tolerate patients behaviour. Their data suggested the integration of patients depended on the type of interaction between the facility and the

community. Liberal, racially mixed, working-class neighbourhoods could enhance the social integration of some clients without conforming to the public stereotypes of a "good" facility. They also suggested that conservative middle-class neighbourhoods were likely to tolerate the competent and least threatening patients. They found that patients with paranoid symptomatology were much more difficult to place in the community and were harder to integrate than patients with schizoid symptomatology. Patients with long term hospitalization did better in working-class neighbourhoods.

Shadish et al (1982) analysed the perceptions of different interest groups of the nature of successful care for mental patients in a community facility. The researcher generated a list of suggestions of successful community care from ten groups in the field. In addition they identified from the literature criteria for successful community care. A total of 18 criteria were selected. Then a questionnaire was formulated out of those 18 suggestions for the respondents to rank according to their importance. The questionnaire was mailed to 108 members of the interest groups. Their results supported the hypothesis that different interest groups in community care e.g. managers in the state department, academics, community agencies personnel, nursing managers, have different views of the characteristics of successful community care. For example, nursing homes groups recognised success in terms of availability of a basic quality of life while Federal and academic groups viewed successful community care in terms of psychosocial treatment e.g. integration and reduction of symptomatology. The results of the study suggested that the success of community care should not be measured on the basis of patient's quality of life criterion only, even within nursing homes, but on the basis of a comprehensive view of the criteria with which to evaluate deinstitutionalization, such as social integration, symptomatology, quality of life, staff characteristics etc. They also concluded that in order to evaluate community care a comprehensive view should take into account both the diverse perception of various interest groups as well as the criteria for success of community care facilities that are actually functioning.

One could conclude that planners of community services need to take into account the views of a variety of groups working with patients in a range of community services about the criteria for success. Seeking staff views could have the advantage of encouraging the staff to feel an active participant in the evaluation of community care rather than being defensive about unavoidable difficulties.

4.5 EVALUATION OF COMMUNITY MENTAL HEALTH FACILITIES

The literature on community care suggests that the objective of community facilities should be to promote both internal and external involvement according to the residents' needs and with an emphasis on independent living. The battle against neighbourhood

opposition should be fought in the court and through social action / advocacy. Location of the facilities should be based on neighbourhood support to enhance residents' social integration. Facilities should provide two types of services, clinical care for the severely disturbed and social support for the less disturbed residents.

Success of community facilities should be assessed not by measuring their success in helping residents to make a transition to full community integration, but by whether or not the residents function at a higher level in community care than they would in a large institution.

Shadish et al (1982) suggested five tasks for comprehensive evaluation of community care. These were:

1. Identifying various interest groups' ideas for criteria of successful community care rather than consulting the literature.
2. Compiling a list of potential success criteria from historical accounts of similar facilities, social theory, expectations of the facility organizers, critics, clients and programme goals.
3. Identifying the preference of each group for each criterion.
4. Seeking views of diverse groups
5. Selecting a subset of criteria that could be evaluated within the time and resources available.

Even though some facilities, such as sheltered accommodation, might not be considered successful on the social integration criteria, they could be successful if judged by basic living needs. In addition, Gomes-Schwartz et al (1978) included that patients' experience could negatively affect the success of a treatment programme.

Shepherd (1983) pointed out that not all patients want to, or will be prepared to participate in a rehabilitation programme. However, a clear plan would provide the staff with the objectives of what they would like to achieve. Staff morale is essential for the rehabilitation process. The patient's attitude toward his illness plays an important part in his rehabilitation.

4.6 Criticism of the Literature Review

A literature search in the area showed clearly a gap in the literature in this country regarding studies carried out to identify nurses' attitudes and roles towards hospital closure. Lack of evaluation of nurses' role in the community might influence the standard of nursing care and consequently patients' adjustment in the community

Various reports stressed the importance of staff training for their new roles in a community-based services such as Bernadt, (1990); Shaw et al, (1990); Royal College of Nursing, (1989) and Bachrach, (1984). Similarly, a number of writers have made recommendations for the nature of such training and the content of training programmes, including the exploration of staff feelings about the transition, such as Davison (1990). In

addition, publications have proffered advice on the management of change for professionals moving from psychiatric hospitals to community facilities. However, there has been no research conducted on staff attitudes to community care and their opinions about the training needed for those facing such a transformation of their work environment.

4.7 METHODOLOGY

4.7.1 Null Hypotheses of the Staff Study

The results of this study will show that:

There is no significant difference in the staff opinions between the first and second occasion regarding their experience of psychiatric nursing, their perception of community care, their satisfaction from working in the community, their perception of their roles in the community and of patients' needs, and their opinions about staff preparation for work in the community.

4.7.2 Sample of the study

Sixteen staff members employed by The Grange to run the scheme were interviewed on both occasions.

4.7.3 Tool of the study

Tape-recorded interviews with 16 staff members when they were appointed and six months later.

Description of the schedule

Staff semi-structured interview schedule (Appendix 5)

The semi-structured interview was developed by the author and consists of four sections. These sections are:

1. Staff personal data. This includes: age, sex, educational background, experience with psychiatric patients.
2. Staff reactions to psychiatric hospital closure. This includes their opinion about the decision to close psychiatric hospitals, their satisfaction with working in the community, their opinion about the effects of hospital closure on the patients, their relatives, staff members at the hospital and the general public. This section also includes staff opinions about the needs for hospital services.
3. Attitude towards community support: this includes their opinions about local residents' reactions to the their presence, patients' integration the neighbourhood and patients' problems that hinder their adjustment in the community.

4. Staff needs for working in the community: This includes staff roles in the community, what is needed to work better in the community, community facilities and services that they had used within six months, as well as preparation required by the patients to help them to re-adjust to the community.

Staff interviews: Six staff members of another project were approached while they were in the hospital preparing for their own scheme. The purpose of the researcher was explained. The same staff members were interviewed after six months for a second time when they moved to their scheme in the community.

4.7.4 Procedures of the study

The objectives of the study were to identify difficulties encountered by both qualified and unqualified staff working in the community through focusing on staff perception of the transition process. A qualitative approach was considered most appropriate and was modelled on the work of Glaser and Strauss (1967). This is particularly appropriate when studying lack of clarity about new roles.

Negotiation of access:

A letter was sent to the staff members as soon as they had been appointed and before meeting them (Appendix 4).

On 7th April 1987, the researcher met with The Grange staff who had been appointed two weeks previously. Discussions involved a hand-out about the purpose and procedures of the study.

This section of the study was conducted to investigate staff perception of their roles in the community. All but one staff member accepted that their interviews would be recorded. The one who refused on both occasions gave no reason. All the staff members were interested and enthusiastic about their interviews. A staff member commented: "I like the way the questions are phrased. It made me think. Nobody asked me before how I got into that sort of business or why I want to work in the community".

Interview

Although the number of staff participating in the study was insufficient from which to generalise, enough data were generated so that conceptual categories could emerge. This study focuses on how the staff perform their role. The 16 staff members participated voluntarily. Interviews were audio-taped, and took between 30-60 minutes to complete. Data collection was completed by the end of June 1988.

Reliability

Reliability of the contents of the tape-recorded interviews was checked by an independent rater.

4.8 RESULTS OF THE STUDY

STAFF REACTIONS TOWARD WORKING OUTSIDE PSYCHIATRIC HOSPITALS

In this section the results of the recorded interviews with staff members when they were first appointed and six months after working in the community will be presented.

Staff members answers will be organized as follow:

1. Characteristics of the staff members.
2. Staff opinions about hospital closure.
3. Staff opinions about the need for hospitalization.
4. Staff opinions about the effects of hospital closure.
5. Staff difficulties during the transition period.
6. Staff roles.
7. Planning of patients' care.
8. Preparation of long-stay patients before their discharge.
9. Community facilities used after six months in the community.
10. Staff opinions about mental health facilities that are still needed in the community.
11. Patients' behaviour that hinders their adjustment in the community.
12. Staff satisfaction from working outside the hospitals.
13. Staff opinions about educational programmes for their preparation.

4.8.1 Characteristics of the staff

The staff members' composition: one manager, a day-centre leader and a residential leader, one occupational therapist, 5 day centre workers and 7 residential care workers (total of 16).

Sex: Ten of the team members are female and 6 male.

Marital status: Nine are single and 7 married or cohabiting.

Age: Eight staff members are between the ages of 20 and 30, and the other 8 are between the ages of 31 and 45.

Educational background: A few staff members were found to have psychiatric nursing training (4,25%), the majority were psychology technicians (5, 32%) without clinical Training, while 3 had some training in social work, one was an occupational therapist, one had a degree in english literature and 2 with no qualification.

Experience with psychiatric patients: Only 7 staff members indicated that they had worked with psychiatric patients in hospitals, 10 had experience of working as a care worker in community facilities (a day centre and out-patients) and one had been involved in rehousing psychiatric patients from a hospital to the community.

4.8.2 Staff opinions about hospital closure

Generally, staff members showed a favourable attitude towards hospital closure.

Table 4.1 Staff opinions about hospital closure

Staff opinion	First interview		Second interview	
	No.	%	No.	%
Strongly agree	7	44	3	19
Agree	8	50	11	69
Disagree	1	6	2	12
Total	16		16	

Positive reactions toward hospital closure were expressed as:

"Institution with minimum number of staff can cause more damage" "Hospitals do not encourage people to get better" "I agree Victorian hospitals should be closed but some types of patients still need hospitalisation" "People are going to be in a more human environment" "Stigma of mental illness will be reduced and staff morale will improve".

Conditional hospital closure:

"I agree with community care but if proper care and reprovisions provided in the community" "If done properly by appropriate training, facilities as well as proper preparation for the patients" "We do not want to repeat the experience of America or Italy. If small units with close proximity to where people want to live. Then people move to ordinary housing to live normal life as possible under close observation" "Patients had not been given enough time to adopt in the community".

Cautious warning:

"I do not believe in the idea behind closing the hospitals, they are closing for economical reasons" "I am uncertain about the value of closing psychiatric hospitals" "Disagree, hospitals closing for political reasons" "We have to be careful, some people need high degree of care".

Negative reactions:

"Putting people in bed and breakfast is not sufficient and they will be forgotten. Unemployment among hospital staff will increase" "Unless the public opinions is going to change, it is going to be very stressful on chronic patients" "Patient's role in the hospital is very limited they will lose their sense of proportion in the community".

4.9 STAFF OPINION ABOUT THE NEED FOR HOSPITALISATION

Fifteen staff members on both occasions indicated the possibility of avoiding hospital admission. Most of the staff members in both interviews suggested the following

measures in order to avoid hospital admission: Primary prevention, crisis intervention, adequate reprovisions, community psychiatric nursing, and reviewing criteria for hospital admission.

From Table 4.2, it can be seen that acute admission units were that the most needed aspect in psychiatric hospitals in the community care era. It was interesting to not that the need for hospital grounds has been greatly reduced by the second interviews.

Table 4.2 Staff opinions about aspects of psychiatric hospitals still needed

Aspects of hospital	First interview		Second Interview	
still needed	No.	%	No.	%
Acute admission	12	75	15	94
Hospital grounds	8	50	1	6
Specialist units, e.g. secure and rehab. dept.	7	44	12	75
Professional staff	3	19	4	25

4.10 STAFF OPINIONS ABOUT THE EFFECTS OF PSYCHIATRIC HOSPITAL CLOSURE

4.10.1 Effect of closure on the patients

As shown in Table 4.3 the staff expressed optimistic expectations toward patient reprovisions in the community. There was increase in staff from 50% to 100% in the staff opinions concerning a better way of life p=0.0391.

Table 4.3 Effects of hospital closure on the patients

Effects on the	First interview		Second Interview	
patients	No.	%	No.	%
Better way of life	8	50	16	100
Fear of unknown	9	56	11	69
Feelings of rejection	5	31	3	19
Fits with patient's wishes	3	19	3	19
Causing confusion	2	13	7	44
Others: losing social network mistrusting non-nursing staff	1	6	5	31

4.10.2 Effects of hospital closure on patients' relatives

Even though 50% of the patients at the Grange have no relatives, staff considered that hospital closure increased relatives' anxiety that they might have to look after their patients (Table 4.4). However, staff reported that more than a quarter of patients' relatives expressed content regarding the move to the Grange.

Table 4.4 Effects of hospital closure on patients' relatives

Effects on the patients' relatives	First interview		Second Interview	
	No.	%	No.	%
Worried that they might have to look after their relatives	15	94	7	14
Anxious about the provision made	9	56	14	88
Positive reactions	6	38	8	50
Ambivalent	1	6	7	44
Fear of unknown	3	19	9	56
Feelings of stigma	4	25	3	19

4.10.3 Effects of hospital closure on hospital staff

The staff at the Grange felt the staff at the two hospitals were anxious about losing their jobs and status as a result of closing the hospitals (Table 4.5).

Table 4.5 Effects of hospital closure on the staff

Effects on the staff	First interview		Second Interview	
	No.	%	No.	%
Worried about losing their jobs	14	88	14	88
Institutionalised like patients	8	50	10	63
Negative attitude to community care	6	38	8	50
Fear of unknown	3	19	8	50
Losing their professional credibility	3	19	7	44
Low morale	4	25	3	19

4.10.4 Effects of hospitals closure on local residents

A staff member said, "It is difficult to assess local residents' reactions, we did not have direct complaints. Some people only stare at us. Some people seemed ignorant about the whole issue. Local shops accepted the staff and the patients alike. Only a restaurant belonging to the social services rejected us. The local police were helpful in bringing patients in when they see them wandering about".

"Local shops had not displayed the posters which we gave them regarding the Xmas Fair".

Even though the staff felt that their presence was not a threat to the local residents and had not received any resistance, they expected or projected their previous experience or preconceived ideas about public rejection of mentally ill people (Table 4.6).

Table 4.6 Effects of hospital closure on the public

Effects on the public	First interview		Second Interview	
	No.	%	No.	%
Prejudice towards mentally ill	12	75	9	56
Fear of the patients	9	56	7	44
Hostility towards patients	8	50	5	31
Worried about the value of property	2	13	6	37
Unaware of hospital closure	4	25	3	19

4.10.5 Staff difficulties during the transition period

Difficulties in working with their colleagues

It was found that the most frequent problems mentioned were: poor communication among colleagues, lack of understanding of each other's roles, and inflexible attitudes.

These were the difficulties encountered among staff members in working outside psychiatric hospitals:

Lack of support from others

In the second interview, lack of support was felt by 5 staff members (non-nursing staff). One felt lack of colleagues' support in the first interview.

Poor communication among colleagues

In the second interview, 9 non-qualified staff and 3 nursing staff indicated that there is poor communication among themselves. None mentioned this problem in the first interview.

Antagonism

Negativistic attitudes and destructive criticism were reported by 6 staff members (3 nursing qualified and 3 non-nursing qualified) in the second interview. This was expressed as: "People are resistant to the idea of community care. One cannot open up communication with the hospital staff regarding organising the client transfer. For example, contradicting what had been agreed on or not keeping records".

Disagreement regarding patients' assessments

More than half of the respondents (4 day centre staff and 5 residential staff members) indicated lack of understanding of each other's roles. This problem posed itself as a disagreement about the criteria for patients' referrals.

Inflexible attitudes

Inflexible attitudes of team members in applying their programme of care was expressed by 9 workers (2 nursing and 7 non-nursing qualified staff).

Lack of privacy

Four on the first occasion felt lack of privacy in undertaking their roles. On the second occasion, 9 felt lack of privacy.

Difficulties in dealing with the local residents

Staff members emphasized the importance of the local residents' attitudes and their education about mental illness in facilitating their roles in the community.

Staff perceptions of the local residents' reactions after 6 months in the area:

There were mixed feelings among the staff regarding public reactions:

Positive perception expressed as:

"I talked to some neighbours, seemed pleased that the building is going to be used. Local shopkeepers are pleased because it is going to bring more trade. They do not seem to mind too much". "The staff in the cafe treated them like anybody else". "Shopkeepers are very good. When they see a patient wandering off, they get in touch with us". "They were tolerant of the way they looked odd". "Been supportive. If somebody has not enough money for a cup of tea, they just gave him a cup of tea without money". "The newsagent, the Irish club and the pub are OK". "They did not take much notice". "Some of the local shopkeepers reacted similarly to how they do with any customers, although others are occasionally unfriendly".

Public rejection was expressed as:

Lack of public acceptance

On the first occasion none of the staff members mentioned problems regarding public acceptance of their presence. On the second occasion, 5 staff members indicated that local residents rejected their presence in the area. "There is occasional hostile reaction"; "There is some hostility especially from the pub; on one occasion the pub owner refused to serve somebody. The side effects of drugs and looking scruffy made people sit apart and stare at us. In Macdonalds they asked us to sit upstairs. In the luncheon club, the club owner told me not to come again". "The manager at Sainsbury's supermarket refused to sell a bottle of wine to a client, due purely to the way he looked. That is a good example of the detrimental way the community behaves to the patients".

Lack of public education

"They have a vague idea of what the Grange is, even though they live opposite us". "When a patient goes out alone to buy something, the shopkeepers phone us to say someone is wandering about".

On the first occasion 9 staff members indicated that the public lacked education about hospital closure and mental illness. On the second occasion, only 5 said that the local residents lacked knowledge.

Staff opinions about the effect of the public on patients' resettlement in the community

"Buying from the shops was helpful in building their self-confidence". "at least it has not affected the clients adversely". "A staff member stated that "There is not much interaction with the public to affect the patients in any way".

Difficulties in dealing with the patients

Slow progress

"I have had to change the care plan several times to keep pace with the slow progress". "A lot of work, then all went in to a bad spell".

Having to explain to the patients about inappropriate behaviour

"Eating all the food at once"

Lack of motivation

"It was so hard to get them to use the day centre or even just to see the place".

Institutional behaviour

"The clients are not used to locked doors, they lose their keys or they do not want to use keys". Wandering about. Not knowing how to handle money. "Heavy smokers who are a fire risk smoke in their bedrooms. Using a gas cooker that has no ignition in it". "Difficulties in expressing their feelings and what they want". "Anxiety, when we went to the luncheon club they could not wait until they served us".

Absconding

A male patient absconded for one day and came back by himself. Another female patient was seen wandering about in the area and brought back by the local police who tend to visit the Grange occasionally and could recognise her.

Monitoring the medication

"We are not allowed to use CPNs, we have to give medication ourselves". "Some are not on any medication".

Difficulties with sorting out financial matters with the DHSS

"DHSS is an ongoing problem, a lot of discrepancy between what benefits they should be getting and what they are already getting".

Physical building

"Difficulty in adapting the building to the people's needs".

Finding suitable accommodation in the community after the Grange
Medical problems "We are not nurses to deal with this problem".

4.11 STAFF ROLES OUTSIDE PSYCHIATRIC HOSPITAL

Staff opinions about their roles in the community

Staff described their roles in the community as unstructured, domestic orientated, encouraging independence, providing individualised care and encouraging self-worth. A staff member viewed working in the community as:

"Qualified and unqualified staff do similar jobs. It is a disadvantage to be overly trained and work in the community". Another staff members differentiated between staff roles in the hospital and those in the community as "Hospital staff tend to foster dependency, being institutionalised themselves, they do things for the patient instead of teaching them how to do it themselves. In the community our role is more difficult. We teach how to do things themselves, it is frustrating and takes a long time".

Staff role expectations in the community

Staff members expressed confusion in carrying out their roles in the community. They identified various reasons for their confusion as: unclear job description, high dependency group of patients, difficulties with various disciplines and poor community facilities.

In the first interview staff members seemed to be unaware of their roles. None of them could describe what their roles were. Only 2 discussed their views regarding their roles. In the second interview 7 staff members continued to express some confusion regarding their roles within the facilities. Two viewed their roles as hierarchical. Three (non-nursing or unqualified) said that even though they feel confused about their role, they have been given no opportunity to learn about these roles. Two felt that they were isolated. Four considered that the present client group is more dependent than they had expected when they first started work. Only 2 said that they found their role more difficult than expected in that they were unsure how to deal with the patients.

It was noted that the day centre staff (5) were more likely to have different expectations about their roles that the residential staff members (2). A manager and 4 (non-nursing) staff members found their roles more demanding than expected.

4.12 PLANNING PATIENT CARE

On asking the staff members if they had their own special plan to develop the present programme of patient care, it was found that there was no agreement among the staff about activities they would like introduced. For example, they mentioned more

outings, introducing an individualistic approach in their rehabilitation programme, increasing the number of staff meetings, using community services, finding more suitable jobs for the patients, designing tools for patients' assessment, and emphasizing patients' participation in household activities and social skills training.

Day centre staff differed among themselves over plans for patient care. However, these differences were not explained by their educational background.

Table 4.7 Differences between day centres and residential staff in number of community services contacted

Types of staff	No.	Mean	St. Dev.	Prob
Day centre staff	6	2.50	.548	.04
Residential staff	8	.88	.354	

There was a significant different ($p<.04$) between residential and day centre staff in the number of community services contacted on behalf of the patients. However, this difference was not related to their prior experience of community care.

Staff members indicated that the methods they used to evaluate their programme of care were: case review, reviewing staff programme and staff meetings.

4.13 PREPARATION OF LONG-STAY PATIENTS BEFORE MOVING TO THE COMMUNITY

It can be seen from Table 4.8, that on both occasions staff considered slow and gradual preparation, social skills training, encouraging self-worth, budgeting and controlling the side effects of the drugs were required for a successful transition. MacNemar Test between the two interviews revealed significant differences in budgeting ($p=0.0313$), individualised care plan ($p=0.0039$), encouraging self worth ($p=0.0215$), controlling drugs side effects ($p=0.0078$).

Table 4.8. Staff opinions about preparation required before discharging long-stay patients into the community

Type of preparation	First Interview		Second Interview	
	No.	%	No.	%
1. Developing self worth	3	19	11	69*
2. Social skills training	10	63	11	69
3. Slow and gradual discharge	10	63	10	63
4. Budgeting	4	25	11	69*
5. Orientation to the area	6	38	11	69
6. Individualised planning	5	31	9	56*
7. Controlling side effects of drugs	1	7	9	56*
8. Personal hygiene	8	50	9	56
9. Household activities	5	31	8	50

* $p<0.05$

Other preparations considered were psychological preparation, using public transport, dealing with everyday life frustrations, as well as sufficient income. The least important items included in preparation programmes were dealing with loneliness, defending oneself and being aware of public attitudes.

4.14 STAFF MEMBERS' OPINIONS ABOUT MENTAL HEALTH FACILITIES USED AFTER 6 MONTHS WORKING IN THE COMMUNITY

As shown in Table 4.9, 56% of the staff members in the second interview indicated that community facilities are completely inadequate in meeting patients' needs in the community.

Table 4.9 Staff opinions about adequacy of the existing community services

Degree of adequacy	First Interview		Second Interview	
	No.	%	No.	%
Fairly adequate	6	37.5	5	31.3
Inadequate	8	50	2	12.5
Completely inadequate	2	12.5	9	56.3
Total	16	100	16	100

Table 4.10 Facilities used by the patients after 6 months living in the community

Facilities used	Residents	
	No.	%
1. General Practitioner	7	43
2. Community Psychiatrist	6	38
3. DHSS	6	38
4. Shops	7	43
5. Local club	4	25
6. Community centre	4	25

Other community facilities used were: restaurants, local library and the public houses. For almost all the above facilities patients never used the facilities individually. They always went in groups accompanied by the staff members in a minibus. Only the local shops were used occasionally by the patients on an individual basis. The pub has been used once by a patient but the barman refused to serve him as he thought that the patient was drunk (the patient had a mild form of dyskinesia in the form of a tremor and slurred speech). A similar incident occurred in a Sainsbury's supermarket when the shop assistant refused to sell a bottle of wine to another patient, claiming that he was drunk.

4.15 STAFF OPINIONS ABOUT THE TYPE OF SERVICES STILL NEEDED

It was noted that in the second interview, 8 staff members felt the need for more education for the public, 9 mentioned suitable accommodation for the patients, more day activities such as: a support group, drop-in centres, and suitable jobs. Only 4 out of 16 staff members felt the need for more training for staff working in the community.

Need for public education: Five staff members in the first interview and 8 in the second interview emphasized the need for public education.

Need for accommodation: Nine staff members in the first interview, and 10 in the second interview considered there was a lack of suitable accommodation for the patients in the community.

Needs for community support services: Six staff members in the first interview and 4 in the second interview indicated the need for community support system such as CPNs, social workers, self-support groups and Day Centres.

Need for more trained staff: More than half of staff members in the first and second interviews, indicated the need for more trained staff to work in the community.

4.16 TYPES OF PATIENT'S BEHAVIOUR HINDERING THEIR ADJUSTMENT IN THE COMMUNITY.

Patients' behaviour that staff members considered as a main obstacle to reintegration in the community was the kind that is disturbing to the public (Table 4.11). In the first interview, 14 of the staff members identified such behaviour as: begging, poor hygiene, picking up cigarette ends, and inappropriate sexual behaviour respectively. The least important behaviour identified were wandering about, aggressive behaviour, and poor communication.

In the second interview, staff members identified the same behaviours from their experience of working with former psychiatric patients, but in a different order, as shown in table 4.12. Other behaviours identified were: psychiatric symptoms of patients, and not knowing the value of money.

Table 4.11 Staff opinions about patients' behaviour that might hinder their adjustment in the community

Type of behaviour	No.	%
1. Behaviour that is disturbing to the public	10	63
2. Wandering about	10	63
3. Poor communication	10	63
4. Aggressive behaviour	6	38
5. Behaviour related to the side effects of drugs	6	38

Effect of education on staff opinions about patients' behaviour that might hinder their adjustment

From Table 4.12, one can conclude that educational background exerted little effect on the behaviour identified.

Table 4.12 Relationship between staff educational background and their opinions about patients' behaviour that might hinder their adjustment in the community

Type of education	Disturbed behaviour	Wandering about	Poor communication	Aggression	Behaviour related to drugs
Nursing	1	3	3	1	1
Non-nursing	7	6	6	5	4
No certificate	2	1	1	0	1
Total	10	10	10	6	6

4.17 WHAT IS REQUIRED TO IMPROVE PATIENTS' ADJUSTMENT IN THE COMMUNITY (number of staff making each suggestion in brackets)

Staff members suggested the following to improve patients' reintegration in the community:

1. Education for the public (6). A staff member pointed out that "Education for the public is important because they are intolerant of patients' unusual behaviour of any sort. Make the clients aware of their behaviour which they cannot handle. It is not always easy to change patients' bad habits. We keep pointing out to them what they should do and what they should not, but we cannot force them to change".
2. Attention to patients' appearance so that they would not look odd (5)
3. Weaning people off drugs (3)
4. More structured activities for the afternoon instead of patients sitting around doing nothing (2).
5. Various groups, role modelling, talking and role play (2)
6. High ratio of trained staff (2)
7. Intensive rehabilitation programme (2)
8. Slow and gradual preparation starting at the hospital to help in building their trust
9. Researching into proper patients' assessment (2)
10. Individual and group activities (1)

4.18 STAFF SATISFACTION FROM WORKING OUTSIDE PSYCHIATRIC HOSPITALS

Staff members were asked in what ways working in the community has met their expectations. In the first interview 11 staff members said that working in the community was a better job prospect, however in the second interview, only 5 staff members considered it a good job prospect. In the second interview, 10 staff members said that the benefit from working in the community was less travelling, while 5 staff members said that they were still uncertain about their satisfaction from working in the community.

On being asked whether or not they would continue working in the community, on the first occasion 7 staff members said that they had a strong commitment toward the patients and community care. However, 5 staff members said that working in the community was unsatisfactory and did not fulfil their expectations, while 4 said they were uncertain whether or not they would continue working in the community.

In the second interview, 14 staff members indicated that they were interested in their jobs and would continue to work in the community. The other 2 said that it was a good experience to help them to achieve further training in clinical psychology.

Staff members expressed their satisfaction from working in the community in the following words:

"I am doing the job which I like"; "It is easier to work in the community than in hospitals". Another person said "I would like to see the project through"; "Better income, interesting experience, but do not like the commitment to eat with the patients"; "Patients' adaptability and resilience better than expected"; "I am amazed that these patients managed to stay in the community".

"It provides a technical training", "Jobs in the hospitals are on the line", "Good way to broaden my experience, I want to have experience in after care"; "I am happier in my social life"; "From experience, hospitals are not going anywhere"; "it is a natural way to work"; "Here I consult 2 people only, but in the hospital it is different". "By and large they improved; there is more eye contact, more communication".

However, other staff members expressed dissatisfaction as:

"There is anxiety about what support the patients will be getting when they move out. The client who moved to an adult fostering scheme is still coming here every day. He is only using the other place to sleep. Obviously these things take time to change".

"Uncertain about working in the community, I feel that there is no care in the community. People do not understand what caring for institutionalised people is all about. There is a lot of hostility in the general public. I feel very pessimistic about community care. General public lacking education. The people who plan it have got not idea, they only provide some money to provide accommodation"; "More responsibilities".

"To be honest, I do not think that we have got our act together. We have got only 2 people moved out. There are no other facilities to move people into or to support people in their accommodation. I feel that we are going to be stuck for some time".

"I am not a very ambitious person, regarding my career working in the community has fulfilled my needs. Regarding the patients, I do not have too many expectations. Some still the same, some have improved. Change is going to be very slow. At least they managed to stay outside the hospital".

4.19 STAFF PREPARATION BEFORE WORKING OUTSIDE PSYCHIATRIC HOSPITALS

The manager at the Grange organised a training week for the newly appointed staff. The main objectives were to introduce the team to each other, to clarify what they expected and what was expected from them, to organise and allocate various activities at the Grange, and to decrease their anxiety. After 6 months, when the staff members were asked whether or not they knew of any training facilities 8 did not know of any. The other 8 mentioned that Haringey training department for social services provides courses and

workshops relevant to what they were doing. Two had already attended a one day workshop entitled "Bridging Gaps in the Community". Another said: "Require funding and not always available"; "there are some workshops for nurses and occupational therapists, but nothing for people with informal training. I need to learn how to teach these skills to the people".

Relationship between staff experience in the community and their opinions about helpful training to work in the community

In the first interview, 12 members of staff indicated that their previous work experience and not their basic education had helped them to work with the patients in the community. After 6 months, staff members considered basic education was as helpful as their work experience. None of the staff members mentioned any approved courses or in-service training they had received as useful in their work.

Staff suggestions of the components for their educational programme

Fifteen staff members expressed the need for further training in order to cope with ex-psychiatric patients in the community.

When asked to suggest items to be included in a training programme, they suggested the following:

The need to learn about medication, psychiatric conditions, coping with violence, rehabilitation techniques, how to work in a team, how to teach patients various skills, social skills and counselling skills, (Tables 4.13-4.20). Other items suggested were: learning the right attitudes towards psychiatric patients, communication skills, current trends in community care, coping with public responses, how to run a group, how to adapt hospital care to community care, how to combat drug side effects, community facilities available, how to establish one to one relationships, experience with psychiatric patients, learning about the effects of institutions on the patients, how to handle crises, legal aspects regarding patients' rights in the community, and first aid.

The MacNemar Test showed a significant difference between first and second interviews regarding: the need to learn counselling skills ($p=0.031$), how to cope with violence ($p=0.039$), and how to work in a team ($p=0.039$).

Table 4.13 1. Learning about medication

Types of staff	First interview	Second Interview
Managers	0	1
Day centre staff	2	2
Residential staff	2	3
Total	4	6

Table 4.14 2. Learning about psychiatric conditions

Types of staff	First interview	Second Interview
Managers	0	1
Day centre staff	3	2
Residential staff	6	4
Total	9	7

Table 4.15 3. Learning about rehabilitation

Types of staff	First interview	Second Interview
Managers	1	2
Day centre staff	2	2
Residential staff	3	5
Total	6	9

Table 4.16 4. Learning about counselling skills

Types of staff	First interview	Second Interview
Managers	0	1
Day centre staff	2	4
Residential staff	1	4
Total	3	9

Table 4.17 5. Learning about social skills

Types of staff	First interview	Second Interview
Managers	0	2
Day centre staff	2	3
Residential staff	0	3
Total	2	8

Table 4.18 6. Learning about teaching patients

Types of staff	First interview	Second Interview
Managers	0	0
Day centre staff	2	2
Residential staff	0	3
Total	2	5

Table 4.19 7. Learning about coping with violence

Types of staff	First interview	Second Interview
Managers	0	1
Day centre staff	0	3
Residential staff	2	5
Total	2	9

Table 4.20 8. Learning about how to work in a team

Types of staff	First interview	Second Interview
Managers	0	2
Day centre staff	3	4
Residential staff	0	4
Total	3	10

It can be concluded that during the transition period staff members expressed interest and satisfaction from working outside the hospitals. However, they considered their roles demanding and involving a lot of domestic activities. They believed that the patients' condition and their quality of life have improved. The staff members indicated that patients' behaviour that is disturbing to the public is likely to hinder them from reintegration in the community. They considered working in the community involves difficulties with colleagues, patients and local residents. They recommended gradual and slow preparation for the patients, educational programme for the public and professional support as well as preparation for the staff.

4.20 DISCUSSION

4.20.1 Methodological Critique of the Study

Using a control group in this study was impractical or impossible because different types of settings in real-life situations cater for different groups of former psychiatric patients. Therefore a quasi-experimental design was adopted and the staff members acted as their own control.

All staff members were interviewed, therefore there was no selection bias except in selection during applying for employment in the community. So they may already have had a favourable attitude to community care and be more prepared to change their work habits.

Small numbers of staff members were interviewed, so there is little statistical power to detect change in attitude. But where significant changes have occurred, they can

be given considerable weight. This study is viewed as a case study providing the opportunity to pilot an innovative questionnaire and to use the respondents' detailed comments to develop the instrument. For this reason the interviews were audiotaped.

4.20.2 Reactions of the local residents:

Staff members indicated that they could not assess the local residents' reactions to their presence in the area because they had not met them. They also felt that their presence was not threatening to the neighbourhood mainly because they had not received any complaints. It seemed that the staff members assumed that the local residents were accepting of their presence while in fact that the majority were unaware of the facility, as shown in the public interview findings (17 out of 47 of the local residents recognised The Grange). Staff members indicated that, even though there was no interaction between the clients and the local residents, they had contributed to building the clients' self-confidence. It seemed that public interaction with the patients could be stimulated by some economic exchange.

4.20.3 Staff attitudes towards working outside psychiatric hospitals

Staff attitudes towards the Grange and hospital closure were mainly positive and indicated satisfaction with their work. This attitude was surprising because in other parts of the interview they expressed doubts about the success of community care. Possibly they were comparing The Grange with the run down hospital. In other sections of the interview staff saw the move into community care in the same way as Collin (1987) described: a cheap option to hospitalisation in which the burden of care falls on the families, friends and neighbours.

One could say that community care has two aspects:

1. Moving patients who have been in the hospital for decades. Patients will need long term rehabilitation, and moving them out of their homes will be a traumatic experience, as they have been accustomed to a fixed routine and a predictable environment. These patients are likely to feel lost, shunned and ridiculed by the community.
2. The patients are not alone in having to face the move into the community. Some psychiatric nurses themselves have spent decades in the hospital, so a similar transition had to be made (Mackay, 1989). If psychiatric care involves nursing in the community, staff members have to undergo further training.

The findings showed that the staff members spoke of many dissatisfactions with their work. There is a general feelings that little or nothing has been done to tackle these areas: lack of support from colleagues, failure of communication, together with increasing demands from hospital staff to accept some patients that they thought unsuitable for their project.

The staff at the hospital also expressed dissatisfaction with issues relating to hospital closure. Moor (1988) surveyed 69 nurses working in Friern Hospital and found that the hospital closure was a "very important" factor affecting staff morale. There was a significant positive correlation between somatic symptoms and concern over hospital closure.

In the current study, patients' increased needs made the key workers feel that they ought to be able to do something more constructive to help the patients, but they found it difficult to do so. Although they acknowledged the usefulness of the staff meetings in terms of support they also found it a tedious part of their job. In terms of the clarity of the workers' role, their goals and responsibilities, the results showed that the less clear the key worker's role is, the greater the strain and anxiety. The less clear responsibilities are, the greater are strain, anxiety, depression and somatic symptoms. These findings confirm much previous research Margolis et al (1974).

Macinick (1990) indicated that responsibility for people has been found to be more likely to give rise to coronary heart disease than responsibility for things. In view of this, training and more information ought to be made available to staff working outside to assist them in clarifying their roles, and objectives.

4.20.4 Patients' preparation for the transition:

Contrary to what one might have expected, instead of having the patients' assessment available as a basis for selection, then providing the data for planning the services, and a comprehensive rehabilitation plan, the community mental health facility was established before identifying the patients and the programme for rehabilitation and the assessment procedures were started long after the patients moved in. Consequently the staff roles were fragmented. They had to employ a number of strategies to discover what was expected from them. Therefore they found many aspects of the transition period stressful. They felt inadequately prepared, both in terms of the situations encountered and the skills required, such as how to teach the patient something or how to counsel psychiatric patients or give medication, as well as dealing with situations where the public were involved, such as the post office or a club.

Staff members initially possessed little information regarding dealing with institutionalized behaviour. However, after 6 months they expressed some understanding for the patients' needs, and knowledge of local facilities even though they did not know how to implement this knowledge and continued to express the need for theoretical and practical education.

The findings of this study strongly support the view that rehabilitation of psychiatric patients should start at the hospital as a means of re-integrating the mentally ill into the community. The findings revealed serious deficiencies in discharge planning and after care service delivery.

The institutional nature of the hospital setting meant that the introduction of ordinary living skills in rehabilitation produced little progress, for example large dormitories and small kitchens, furthermore hospital staff were unfamiliar with community care. Practically one could say that the patients were moved to another place within the community rather than socially reintegrated.

Patients were moved from the hospital more or less at the discretion of the staff and in accord with patient willingness to visit The Grange. The issue in selection as to how make them socially accepted was neglected. One could point out that rehabilitation should aim at developing patients' autonomy and the ability to cope with daily living. What rehabilitation means, how it can be achieved and what purpose it should serve are questions that need to be understood within the context of community care.

This study suggests that the standard of patient rehabilitation in the community might be reduced if the majority of care staff are non-professional. One could add that it is unjustifiable to ignore public role in planning and success of community care on the ground of difficulties or complexity, if community care is going to be successful.

When the preparation gradually merged into the moving process, planning took little regard of the preparation both patients and staff might need in order to cope with the change. In the hospital, the staff relied on the Grange for rehabilitation and little attention was paid to the patients' needs. For instance they were not given the opportunity to talk about their feelings and the issues of discharge, or offered a reminiscence group in order to get support. While the staff at the hospital indicated they knew the patients well, the selection of patients was left entirely to the key workers from The Grange.

These factors made The Grange staff feel without support, isolated and uncertain of their ability to cope with the situation. These circumstances were reflected in the pattern of communication among themselves. The Grange staff felt a threat and distrust on the part of the staff from the hospital. They wanted assurance that the researcher did not work for the NHS, and a promise not to divulge any information to the staff at the hospital.

4.20.5 Problems of the transition period

The greatest number of troubles in transition of care were predicted, and reported such as that staff interest dropped, and their pessimistic expectations were increased by experience. Poor communication produced lack of understanding of the roles, and considerable staff distress was occasioned by special administrative problems. The staff at The Grange felt pressure to achieve marked change in inpatients' behaviour and quick discharge from the hospital. In addition, the stress of the transition was compounded by lack of opportunity to adjust to their new role before helping in the patients' transition. Most of the staff indicated that they would have appreciated some experience or training in the field.

Lack of agreement on establishing assessment and rehabilitation procedures underline the importance of a multidisciplinary team during the transition period in creating a community based services. Early disagreements between social services, task force representatives, and hospital staff over the nature of assessment were never fully resolved and led to underlying difficulties for the different groups involved in developing a coherent and common strategy for change.

Aspects of care found to be demanding are: supervising patients and dealing with difficult situations such as those involving potential violence feeling under pressure to get more work done, carrying out distasteful tasks and coping with incontinence which they considered nursing activities rather than the key worker's job.

The closure of the hospital seemed to have an important effect in ensuring high staffing levels in the community. This has a good effect on the patients' hygiene and interaction. The overall results suggest that as support is perceived to decrease, so strain increases. The crucial support factors perceived were psychiatric information received from the project manager and community psychiatrist. Lazarus (1966) found that perceived lack of support from colleagues and nursing seniors was related to strain by others.

One could argue that patients' resistance to the initial move could be partly attributable to staff attitudes. The low morale of the staff and lack of information about community care made them uncertain of the ability of the dependent patients to cope outside hospital. In addition their educational background and experience made them ambivalent about the success of community care.

Factors that contributed to staff anxiety:

A. Crises involving patients which they had no experience in dealing with.

B. Lack of back-up services [CPN/Social Workers] even though they had a significant input from the community psychiatrist.

C. The pressure from hospital staff to refer more patients to the Grange. This strained relationships between the Grange and hospital staff.

The purpose of this discussion is to identify the steps which should be taken to ensure support is present. This is best achieved through making the planning team more aware of these problems in order to clarify the role staff play and letting them determine how best to improve communication. Further research could pinpoint more precisely where support is lacking.

4.20.6 Staff roles outside psychiatric hospitals

The staff members expressed confusion concerning their roles and could not identify the difference between the roles of qualified and unqualified staff in the community. They considered that qualifications are not needed in to work in the community. This raises concern about quality assurance and quality improvement of

community care. One could argue that qualified staff might feel apprehensive about working in the community because they have not had the preparation and experience required for this work. If unqualified staff continue to be employed, this will add to the dilemma of qualified staff who might stop seeking employment or further training for work in the community; consequently the standard of community care will be questionable.

When the staff were asked about their roles, they said that there is not a clear job description and that they learn their roles as they go along. They also found some parts of their job were too difficult to perform. Nevertheless, the results revealed aspects of the nursing situations which lend themselves to possible improvement through training and greater awareness of the type of support needed.

The role of 'a key worker' requires assessment and decision-making abilities that are based on knowledge and experience in planning, making appropriate judgements and being accountable for one's judgements and actions. Preoccupation with the problematic aspects of the relationship between the staff at the hospitals and the residential workers could interfere with patients' rehabilitation programmes. In addition, the presence of key workers with different concepts and background at the same facility presented a conflict regarding professional issues.

Even if psychiatric nurses moved from hospitals to alternative community settings a change in role would be required, otherwise there would be a real danger of not improving the services. There is an imperative need for in-service training or re-education prior to the change. Even when staff transfer with the patients from the wards, therefore, education is still needed to orient nurses to their role in the community.

4.20.7 The need for training

The results showed that the key workers who were responsible for the patients' day to day care in helping them back into the community had minimum or no experience in rehabilitation.

Other experiences in community care demonstrated success such as the Exeter service. McCausland et al (1990) considered that the reasons for its success were the establishment of clear strategies for re-location of the services, agreed personnel practices which encouraged staff commitment and prepared people for future roles, and involvement of staff in detailed planning of the new services.

Some studies of rehabilitation indicate that it should start at the hospital. One could argue that Friern and Claybury hospitals are not equipped to provide adequate preparation for community care. However, it is illogical to scatter the mentally ill in the community without proper preparation. One could suggest that the local authority should revise their present in-services training for the community facilities. Personal observation revealed severe deficiencies in top staff with the right attitudes and educational background to

provide such training. Community services will not operate properly unless there was organised liaison between the hospital and local authority.

The data from this study indicated that the staff role in the community is vastly different from that in the hospital, However, there are some basic skills that qualified staff might be familiar with. One could argue however that managerial as well as problem solving skills should be included in training programmes.

Staff need training not only to fulfil their own roles, but to understand the contribution of other professions to community care. The one week induction course was considered by the staff insufficient to learn about community care furthermore, the programme of rehabilitation at the Grange was relatively unstructured. This led to the development of a style of work based on individual initiative, especially from the qualified staff.

The staff members had to deal with a population characterised by apathy, and lack of initiative, used to isolation. The majority of psychiatric patients lost all contact with their immediate relatives and the hospital became a home to them (Friern survey, 1985; TAPS, 1990).

It could be concluded that at this stage in the rundown of psychiatric hospitals, the discharge and resettlement of the remaining patients has become very difficult and is only likely to be achieved successfully after a lengthy process of rehabilitation. These results suggest that information about rehabilitation and the effects of institutionalization should be monitored and incorporated into staff training courses. Similarly, training may be required to help the staff to deal more effectively with patients' families. This could take the form of being trained to deal with patients' institutionalisation problems or develop practical solutions to cope better with patients' problems.

5. INTEGRATION OF THE FINDINGS FROM THE THREE PARTS OF THE STUDY

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The results of this study raise concern regarding the patient in the community on the following counts:

1. Patients' lacked a range of facilities available,
2. Their disabilities had a major effect on their transition to the community,
3. The patients moved to a situation of uncertainty, while staff themselves had little information and skills to offer.
4. The local residents maintained stereotype attitudes toward former psychiatric patients but the majority would welcome prior preparation and information about mental illness.
5. Public beliefs are not entirely unfounded, as the results showed deterioration in patients' mental and social state.
6. The local residents' attitude toward community care is influenced by the general political atmosphere and the media.
7. The planners believed that principles of normalization are served by avoiding informing the local residents and employing unqualified staff. They confused the principles of normalization with shielding their patients from their local community. Their criteria of success were lack of local residents' opposition and complaints rather than local residents' acceptance and positive attitudes toward former psychiatric patients moved to live in their neighbourhood.

Staff Approach To The Neighbourhood:

Even though the project policy was to inform the local residents, little real effort was made to involve them, for example the opening of The Grange was announced in the local paper but only two respondents had seen it.

Local residents interviewed knew about The Grange through observation and informal contact. The first formal contact the staff members had with the local residents was during the opening day and Christmas fair through letters left at the doorway of the ground floor of buildings. As a result residents on the upper floors had not received any of The Grange letters.

One of the respondents said that nothing in the staff letter indicated that the fair was for the benefit of former psychiatric patients. Even though there was a banner and music, local residents were not attracted to the function. Most local shopkeepers attended who had been approached personally by the staff. The point to be made here is that the local residents need meaningful interaction with the staff if they are to be involved with the facility.

One would expect that setting clear goals and implementing them would be of paramount concern for the professionals developing new community mental health facilities. However, the political and administrative considerations involved in this task were immense as described by the project manager. One could say that one of the problems was the lack of agreement as to the policy concerning approaching the public when establishing a mental health service in the community.

The area of public attitudes is very complicated, involving professional activities and responsibilities as well as the public. A conclusive answer cannot be achieved through this research project, but at least it highlighted important issues for future study.

Even though this research project received acceptance from various ethical committees, planners resisted the idea of approaching the public. Their main concern was that researching into public attitudes could stir up their opposition and crystallise negative attitudes toward former psychiatric patients. The results of this study proved that these anxieties were unfounded as there was no change in public attitudes between the two surveys.

It seemed that professionals involved in planning the transition wanted to continue with closing hospitals in the same pattern as during the era of the open door policy. Planners should recognise that the current situation is quiet different from the open door policy era because patients were often discharged to live with their families and they were not severely institutionalised.

This bring out the question of how far a person is required to change to fit social norms or whether social values can be made more flexible to accommodate many of those who are now seen as outsiders. It seems that community care is understood by some planners as "containing" the mentally ill in the community rather than as integration into the community. The complex issue of patients' quality of life needs to be evaluated in the light of public attitudes and their perception of former psychiatric patients moving into their neighbourhood.

An important question that needs to be asked is whether neighbours' attitudes toward the residents were a significant factor for residents with severe mental disorders? Furthermore, was isolation of patients from the neighbouring community a consequence of their behaviour? Another question to be considered is the reasons why local residents expressed more positive attitudes towards mental health facilities.

6. SUMMARY AND CONCLUSION

6. SUMMARY AND CONCLUSIONS

6.1 OBJECTIVES OF THE PROJECT

The research project intends to identify:-

1. Patients' attitudes towards living outside the hospital.
2. Patients' social behaviour after 6 months living outside the hospital.
3. Patients' mental state after 6 months living in the community.
4. Staff's problems encountered after working for 6 months in the community.
5. Staff needs in working outside the hospital.
6. Public concepts about mental illness.
7. Public reactions towards former psychiatric patients in their neighbourhood.
8. Changes in public attitudes.

6.2 DESIGN OF THE STUDY

This study employed an experimental design. Two groups of the local residents were identified: a study group and a control group. The study group consisted of 68 of the immediate neighbours of a group of patients discharged from Friern and Claybury Hospitals. The control group comprised 60 of the residents of a road parallel to that of the study group, to minimize the likelihood of contact with the patients in the study area. Door-to-door interviews were conducted using a semi-structured schedule with the local residents before the patients moved into the community and six months afterwards. Tape recorded interviews took place with the staff employed to look after former psychiatric patients as soon as they were appointed and six months after working in the community. The patients were interviewed while they were in hospital after they had been identified by the staff members and six months after living in the community.

6.3 SUMMARY OF THE PUBLIC STUDY

About one third of the respondents (32%) interviewed initially did not participate in the second interview. Comparison of participants and non-participants in both groups in the study showed no significant difference in their sociodemographic characteristics suggesting that there was no selection bias from refusals.

A high proportion of both groups reported contact with mental illness, 19% in the study group and 11.7% in the control group. They described the conditions as nervous breakdown or depression. Almost half the subjects in both groups had relatives with mental illness or knew somebody who was mentally ill.

Seventeen subjects out of 47 indicated that they had talked to residents of The Grange or recognised the building.

When local residents were asked about their relationships with their neighbours, they expressed their opinions without hesitation even though in some instances these were

negative. By contrast, when they answered the same question regarding their relationships with a mentally ill neighbour they were hesitant and seemed ambiguous in expressing their opinions.

6.4 CONCEPTS OF MENTAL ILLNESS

Analysis of the results showed that sociodemographic characteristics had no effect on public opinions about mental illness.

There was no significant change in public attitudes towards mental illness between the two occasions. However, on the second occasion there was a tendency towards positive change in the study group and, opposite to what was expected, there were negative changes in the control group. This was explained on the basis that the local residents confused mentally ill people with vagrants, a fact that emerged from the Repertory Grid analysis.

Possible interpretations of lack of change in public attitudes are:

1. Local residents construed mentally ill people from their previous experience or what they had learned from the media rather than from their contacts with the patients who moved to their neighbourhood.
2. Staff members were over-protective and prevented contact between the patients and neighbours.
3. Direct contact with the mentally ill was not enough to change public attitudes.
4. The small number of subjects who participated in the study.
5. The presence of the mental health facility in the area did not disturb the local residents, consequently there was no negative reactions to the patients' presence in the neighbourhood.

A quarter of both groups said it was difficult to identify mentally ill people. The remaining three quarters of interviewees indicated that mentally ill people could be identified by difficult communication, bizarre behaviour, lack of social skills, behaviour that is disturbing to the public, abnormal appearance, distressed behaviour, aggressive behaviour and wandering about.

Having a mentally ill person as a next door neighbour is likely to arouse anxiety for the local residents. This is because the mentally ill person was preconceived as being aggressive, unpredictable and potentially disturbed.

Mental illness was construed as a strange, serious or vague condition, depressed state or just a disease. Psychiatric patient's behaviour was viewed as lacking social skills and infantile.

Even though the study group indicated more contact with the mentally handicapped due to the presence of a mentally handicapped hostel in the area, they showed no difference in their perception of them. Both groups considered appearance, behaviour and interaction as the most salient factors in identifying mentally handicapped people.

A mentally ill person can be identified from his behaviour and interaction. The behaviour of mentally ill people was identified as the most important indication of the illness in the first interview ($p<0.01$). In the second interview, patient's mood was considered most important ($p<0.05$).

Social factors were considered the most important cause of mental illness, such as separation, divorce, death in the family, unemployment, high work load, poor housing conditions, and stresses and pressures of life. Other causes cited were personality, chemicals or toxins in food, physical illness and politics, heredity, addiction and upbringing.

Interestingly mental illness was perceived as a curable condition compared with other chronic conditions such as mental handicap, diabetes and epilepsy. An equal number of local residents considered mental illness curable as the number who considered it incurable. Nearly half of the respondents on both occasions considered that the prognosis of mental illness depends on the severity of the condition as well as its cause in the first place, that is to say if due to heredity, it will not be cured.

6.5 REACTIONS TOWARDS CHRONIC CONDITIONS:

Local residents considered that diabetic and epileptic people are almost impossible to identify. Respondents made a clear cut distinction between nervous breakdown and mental illness on the basis of the cause of the conditions ($p<0.021$).

In both interviews,local residents showed more sympathy towards mentally handicapped than mentally ill people. On both occasions nearly half of the local residents showed great interest in donating money to charitable organisations for mentally handicapped people, while only a quarter of the residents were likely to donate for the mentally ill. Main reasons given were personal contacts with the mentally handicapped, the severity of mental handicap, and feeling pity for the mentally handicapped.

Local residents were more willing to rent a room to a diabetic than to any other group. Even though three quarters of the residents in both areas in the first interview said that they would attend a club also attended by the mentally ill, they showed little interest in socializing with mentally ill people. On the second occasion, both groups showed less interest in attending such a club. About half of the residents laid down conditions for working with mentally ill people.

6.6 OPINIONS ABOUT MENTAL HOSPITALS

Local residents who were in favour of mental hospitals claimed them to be the most suitable place for treating mental illness, specifying that they were reliable, safe places, helped to change the environment, and were competent in treating the illness. However, local residents who were unfavourable towards mental hospitals, criticized them for their physical settings, their treatment, and negative attitudes of the staff.

One third knew somebody in a psychiatric hospital, and half the respondents said they would admit their relatives to a psychiatric hospital, Although a high proportion chose hospitalization for their relatives, when it came to themselves they preferred treatment in the community.

6.7 REACTIONS TOWARDS A MENTAL HEALTH FACILITY IN THEIR NEIGHBOURHOOD

An overwhelming majority of the local residents showed positive attitudes towards the opening of a mental health facility in their neighbourhood. They also showed an interest in offering help to the facility. They indicated that mental health is lacking facilities and that it is time for the government to open more facilities in the area. They also mentioned that they might use these facilities in the future, and it would help them to understand the illness. The study group indicated that the Grange caused no disturbances to the neighbourhood and that the clients were accompanied by the staff members most of the time. Local residents who opposed mental health facilities in their area considered that what the mentally ill need is professional help.

6.8 WAYS BY WHICH THE LOCAL RESIDENTS CAME INTO CONTACT WITH THE GRANGE RESIDENTS

There was little direct interaction between the local residents and the residents of the mental health facility. Most interactions were as a result of the local residents' personal observation rather than the staff members' efforts to liaise with the local community.

6.9 THE ABILITY OF FORMER PSYCHIATRIC PATIENTS TO LIVE IN THE COMMUNITY:

Even though half of the respondents considered that the mentally ill could live outside psychiatric hospitals, they were of the opinion that staff-supported accommodation is essential for their survival in the community.

6.10 PUBLIC OPINIONS OF COMMUNITY CARE:

Half of the respondents knew about the decision to replace psychiatric hospitals through talking to friends. Local residents expressed enlightened views concerning community care such as:

1. The need for preparation of the patients and the staff.
2. Conducting experiments to find out whether or not community care is working before closing the hospitals.

Community care was seen as isolating patients, lacking professional support, facilities and expertise. Moreover, it was considered to be in the politicians' interests rather than the public interest in order to save money and achieve privatisation of the

hospitals. This was inferred from the practice of ignoring public opinion and neglecting to inform them about the decision to close psychiatric hospitals. Local residents who preferred community care considered it more normal than hospital treatment, wanted to be in a familiar environment and considered it less stigmatizing.

6.11 PREPARATION REQUIRED BEFORE PSYCHIATRIC PATIENTS MOVE IN TO NEIGHBOURHOOD:

Local residents requested the following information:

1. Background information about the patients
2. Types of supervision they have
3. Knowledge about the facilities available
4. Information about the facilities themselves.
5. Practical skills to approach these patients.
6. Services to be contacted in case of trouble due to the presence of mentally ill people in their neighbourhood.

Local residents expressed the need to know whether any other mental health facilities would be opened in their area. More than half of the subjects in both groups on both occasions indicated that it is important to prepare the local residents before opening mental health facilities in their neighbourhood. More than half of the respondents were interested in medical knowledge, 15% were interested in psychological preparations. Nearly a quarter wanted information about the patients' behaviour. Residents living with others showed more positive reactions towards preparation than single residents ($p<0.041$). Females in both areas showed significant differences from males in their need to learn about mental illness in general ($p<0.003$) and to learn about the services available ($p<0.041$).

Whereas home owners were more interested in reassurance regarding the mentally ill, for example, dangerousness of mental illness, percentage of mental illness in the area, council tenants were more interested in education about mental illness, for example, the causes of mental illness, type of treatment available.

In the first interview, the study group showed interest in learning through door-to-door discussion,then newsletters, while the control group preferred instruction through the media, then newsletters. On the second occasion, both groups chose the media, then newsletters, then door-to-door discussion. Both groups explained that the media are cheaper than door-to-door discussion, reach a large number of people, and involve visual images. They suggested providing a telephone number for more information. Minority groups suggested discussion in the social club for different minority groups in their own languages. Local residents who rejected education about mental illness explained that people would not give attention to the information unless

mental illness concerned them in a personal way, in addition it could lead to fear, like publicity about AIDS.

6.12 EDUCATION ABOUT MENTAL ILLNESS:

It can be concluded that local residents who did not want any preparation or could not decide about what they needed:

1. expected that the professionals should take responsibility for discharged patients
2. were concerned that the preparation might induce fear of mental illness, such as AIDS.
3. were not interested in community care
4. were mistrustful of the administrators and the politician and believed that they will enforce their policies regardless of public opinion.

6.13 CHANGES IN PUBLIC ATTITUDES TOWARD FORMER PSYCHIATRIC PATIENTS IN THEIR NEIGHBOURHOOD: QUANTITATIVE RESULTS FROM THE REPERTORY GRIDS

In this study two major dimensions of perception emerged. The residents viewed the elements in a simple form either positive or negative which resulted in the emergence of a good/bad pole and polarization of the constructs. Some elements were construed in the same way as the mentally ill in both groups on both occasions, such as vagrant, alcoholic and mentally handicapped, while other elements were more distant, such as person you like most as a neighbour, person who is generally healthy and an unemployed person.

A mentally ill person was viewed with fear, and expected to show unpredictable behaviour and difficulty in communication. The "social distance attitude" which reflects lack of contact with mentally ill people leads to viewing them as strange, bizarre, and unfriendly. The social distance remained stable between occasions and groups. as the subjects applied the same standard in ranking the degree of association between the 234 variables. The control group construed mentally ill people similarly to a vagrant person. This result is particularly important to the staff, who need to try to improve patients' appearance and to involve them in a structured programme of activities to occupy their time.

Few positive changes occurred in the major attitudes to the mentally ill but there was a change in minor attitudes like noise and minor local disturbance. The results obtained by correlating the constructs showed that some constructs remained stable in their association with the mentally ill in both groups, such as difficult to talk to, dangerous to himself, changeable, unfriendly and aimless. The principal component analysis showed that the changes were interrelated and concentrated in quite a small number of dimensions.

No significant difference was found in the interaction between occasion and locality. However, there was a slight positive change in the study group's views about mentally ill people. Only 2 individuals out of 8 showed negative change in their views towards the mentally ill. In the control group the mentally ill were seen as relatively negative on the second occasions. Five individuals out of 10 showed a slight negative change, and only 2 showed relatively marked changes in their views of the mentally ill between both occasions.

6.14 SUMMARY OF THE PATIENTS' STUDY

Characteristics of the Study Groups:

A total of 20 patients were interviewed. Eleven (5 males and 6 females) were residents at the Grange and 9 (6 males and 3 females) were daily commuters from Friern and Claybury Hospitals.

Social Network: the results showed a significant increase in the size of the social network of both the residents and commuters between baseline and 6 months. This increase was mainly in the number of professional contacts rather than other patients and relatives. While at 6 months the number of professionals named was a combination of the staff at the hospital and the staff at the community residence, at one year the professionals named by patients were only those at the community residence. It was interesting to note that not one of the neighbours was included in their social network by the residents even after one year of living in the community.

Attitudes toward community care: At baseline, 10 patients out of 15 expressed a strong or qualified desire to leave the hospital. After 6 months 13 out 17 patients wanted to leave the hospital while at one year 10 out of 17 patients indicated that the community residence was preferable to the hospital.

Patients' social behaviour showed no significant difference but there was a tendency towards improvement over time, specially in the areas of personal hygiene, ability to initiate interaction, underactivity and ability to make social contacts. Areas of social behaviour that showed no change over time were posturing and mannerisms, oddity of conversation, overactivity, laughing and talking to oneself and slowness. Areas that showed a non- significant deterioration were socially unacceptable behaviour and hostility. Anxiety showed a near-significant increase over time (exact $p<0.054$).

Mental State: The scores on each syndrome were summed to produce a total DHA score which was compared across the three occasions of rating. The results of this analysis showed that the residents were more likely to express delusions and hallucinations in the community than the commuters: Disturbances in perception showed no improvement after one year. Similarly the BSO score showed a significant deterioration at 6 months ($t=2.96$, $p=0.0081$). Analysis of the observed behaviours that make up the BSO score showed a

trend towards improvement in patients' self neglect, but slight deterioration over 6 months in observed anxiety and depression. Then slight improvement occurred after one year especially in the area of bizarre behaviour and restricted quantity of speech.

PSE data showed a significant difference over time with respect to the severity of symptoms. It was found that Index of Definition (ID) level rose significantly between baseline and 6 months ($t=4.234$, $p=0.004$). Summary statistics for time by ID indicated a highly significant deterioration in the mental state of all 20 patients in the community. This deterioration was greater at 6 months than at one year.

The environment of the community facilities was relatively permissive: the average total score was less than half the hospital score: Repeated measures t test was highly significant ($t=5.60$ $p=0.001$). The permissive environment persisted at 12 months.

6.15 SUMMARY OF THE STAFF STUDY

Staff members expressed positive reactions towards hospital closure on condition that adequate reprovision was ensured in the community. Others were cautious, warning that the American and Italian experience in closing psychiatric hospitals should be followed with adequate studies to investigate the feasibility of community care in this country. Others were uncertain about the value of hospital closure.

Fifteen staff members on both occasions indicated the possibility of avoiding hospital admission. On the first occasion, 75% indicated that acute admission is the most important feature of the hospitals and 50% considered that hospital grounds were the most important. In the second interview, 94% said that acute admission is the most needed aspect, however, only 6% considered that the hospital sites were still required. Interestingly, 75% indicated that the rehabilitation department is the most important aspect of psychiatric hospitals. Most of the staff on both occasions considered that patients' quality of life is better in the community than in the hospital; however 69% indicated the there is an element of fear and anxiety of the unknown concerning the patients' future in the community. Almost all the staff (94%) in the first interview mentioned that patients' relatives were worried about the possibility of having to look after the patients, whereas only 44% in the second interview did so. In the first interview 56% were worried about the extent of provision in the community compared with 88% in the second interview.

Staff perceptions of the local residents' reactions towards former psychiatric patients in their area.

Though local shopkeepers were welcoming and co-operative, they did not display posters advertising the patients' Christmas fair, and local residents ignored the event. Staff members said they had not received any complaints but local residents did tend to stare at them or avoid sitting close to them in the local pub or club.

Five staff members experienced negative reactions in the area which indicated lack of public acceptance of their presence and their ignorance about mentally ill people. For

example, Sainsbury's manager refused to sell a bottle of wine to a client, the local pub refused to serve alcohol to a client, a manager in a Luncheon club, asked staff members accompanying a group of clients not to come back again. Local shopkeepers would also telephone the staff when they saw a client walking by himself to say that there was somebody wandering about.

On the other hand, staff members indicated that, even though there was not much of an interaction between the clients and local residents, neighbours had contributed to the building of client self-confidence, for example being patient when clients made purchases from them in shops.

Staff difficulties in dealing with the patients:

Areas of difficulty highlighted by staff were: patients' slow progress, having to explain to the patents about inappropriate behaviour, lack of motivation, institutional behaviour, absconding, monitoring their medication, difficulties with sorting out financial matters with the DSS, finding suitable accommodation in the community and the clients' medical problems.

Staff roles in the community:

Staff described their role in the community as unstructured, domestic orientated, encouraging independence, providing individualised care and encouraging self-worth.

Half of the staff members expressed confusion about carrying out their roles in the community. They identified various reasons for their confusion, including lack of a clear job description and poor differentiation between qualified and unqualified staff roles.

There was a significant difference ($p<.04$) between residential and day centre staff in the number of community services contacted on behalf of the patients. However, this difference was not related to their prior experience of community care.

Even though there was not a structured programme for the day centre, staff members indicated that the methods they used to evaluate client's activities were: case review and reviewing staff activities during their meetings. However, there was no agreement among the staff about activities they would like to introduce.

Staff difficulties in dealing with their colleagues:

Staff members identified their difficulties as lack of support from others, poor communication among colleagues, antagonism, disagreement regarding patients' assessment and inflexible attitudes.

Preparation of long-stay patients before moving to the community:

On both occasions staff considered that slow and gradual preparation, social skills training, encouraging self-worth, budgeting and controlling the side effects of the drugs were required for a successful transition. McNemar Test between the two interviews revealed more frequent mention on the second occasion of budgeting ($p=0.0313$), individualised care plan ($p=0.0039$), encouraging self worth ($p=0.0215$),and controlling drugs side effects ($p=0.0078$).

Other behaviours identified included the psychiatric symptoms of the patients, and not knowing the value of money.

Patients' behaviour that hindered their adjustment in the community:

In both interviews the staff members identified behaviour that was disturbing to the public, for example, begging, poor hygiene, picking up cigarette ends and inappropriate sexual behaviour. The least important behaviours identified were wandering about, aggressive behaviour and poor communication.

Suggestions to improve patients' adjustment in the community were: education of the public, improving patients' appearance, weaning off the drugs, afternoon structured activities, higher ratio of trained staff, intensive rehabilitation programmes, slower paced preparation, researching into proper patient assessment, and individual as well as group activities.

Community Facilities:

The most frequent facilities used by the clients within 6 months were the G.P, community psychiatrist, DSS, shops, local club and community centre. Community services were considered completely inadequate by over half of the staff members. Facilities still needed were: public education, appropriate accommodation for former psychiatric patients, community support services such as CPNs, social workers, day centres and self support groups as well as trained staff.

Staff preparation before working in the community:

None of the staff members mentioned any approved courses or in-service training they had received as being useful in their work.

They expressed the need to learn about medication, psychiatric conditions, counselling skills, coping with violence, rehabilitation techniques, how to work in a team and how to teach patients various domestic and social skills. Other items suggested were: learning the right attitudes towards psychiatric patients, communication skills, current trends in community care, coping with public responses, how to run a group, how to adapt hospital care to community care, how to combat drug side effects, community facilities available, how to establish one to one relationships, experience with psychiatric patients, learning about the effect of institutions on the patients, how to handle crises, legal aspects regarding patients' rights in the community, and first aid.

The McNemar Test showed significantly more frequent mention on the second interview regarding: the need to learn counselling skills ($p=0.031$), how to cope with violence ($p=0.039$), and how to work in a team ($p=0.039$).

Overall, staff members expressed interest and satisfaction in working outside the hospitals even though they considered their roles as being demanding and involving a lot of domestic activities. They believed that the patients' conditions and quality of life had improved.

7. RECOMMENDATIONS

7 RECOMMENDATIONS

7.1 RECOMMENDATION FOR FURTHER ACTIONS

The results of the study suggest a number of actions to improve staff activities and public attitudes in order to help patients to readjust to life outside psychiatric hospitals and to facilitate the transition from hospital care to the community:

1. To change public attitudes, barriers to effective communication between staff and local residents should be removed. The likely consequences of removing barriers are reduction of fallacious stereotypes, and the substitution of realistic views for public fears. The core team of each mental health facility should concentrate on their immediate neighbourhood and focus their efforts on a small group of residents. They should identify individuals with positive attitudes and help them to see how their contribution could fit into the general care of former psychiatric patients by helping them with their daily activities. Acceptance and change in attitudes involve a continuous process, and providing knowledge would not be effective by itself but finding the appropriate approach and the right frame of mind is important. One approach could be through some of the local residents who expressed willingness to offer help in shopping, accompanying patients or providing entertainment.
2. The results of the study indicate that a programme of public education should attempt to reach out to ethnic minority communities by using their languages.
3. To win public acceptance of community care it is necessary to establish adequate and efficient services to replace psychiatric hospitals. According to the results of this study the local residents indicated the need to know how their money is spent when psychiatric hospitals close. The aims should be to develop various facilities and efficient staff and to consult the public about their mental health problems and the type of facilities that they might need in their area in the future.
4. The results substantiate the fact that those identified as mentally ill were feared. Segregation of patients from their local community proved to be unhelpful for both local residents and former psychiatric patients. Frequent interaction would help the public to learn about mental illness and thereby to lose their fear, and former psychiatric patients would be helped to develop social skills and self-confidence. This should eventually lead to their integration in their local community. Adequate preparation and support should be offered to both patients and staff members.
5. Community care represents a challenge to traditional care. There should be less reliance on untrained nurses because there is a great need to gain public confidence in the professionals. Negative attitudes held by staff may lead to the collapse of community care. The new pattern of delivery of care means new roles and status for the staff. One could argue that these new roles could be carried out only by qualified staff.

6. The complexity of patients' needs requires an adequate range of facilities available for them in the community. The presence of such facilities offers a sense of security to the public that former psychiatric patients would not be a burden on them.
7. The problem of wandering in the area could be partially solved by opening psychiatric facilities near parks or with large gardens.
8. The public could be reassured by advertising sources of help either for themselves or for former psychiatric patients moved to live in their neighbourhood. This also could improve public awareness of mental health in general. Facilities which are staffed 24 hours offer some reassurance to the local residents, who consequently do not object to having them in their neighbourhood.
9. The media have a crucial role in influencing public attitudes toward mental illness. Balancing facts about mental illness is essential in any programme of public education.

10 Understanding mental illness and the history of institutions and their psychological effects on the patients could help the public to sympathise with former psychiatric patients and understand some of their disabilities.
11 In order to improve the prospects for community care, mental health education should be introduced as part of reprovision in order to help the public to conceptualise the importance of community care for former psychiatric patients, and to allay public fear of mental illness. Public attitudes toward community care seemed not to be so
crystallised as to be impervious to such education.
12. Patients' social skills training should focus on more realistic behaviour, for example, using situations and incidents between patients and local residents to teach patients how to deal with such situations.

7.2 RECOMMENDATION FOR FURTHER RESEARCH

1. One could suggest a replication of public interviews using a large sample size and a longer length of follow-up for example one year.
2. Research is required to identify the factors that lead to positive public attitudes. This could be carried out using the same questionnaire with a more heterogeneous population. The sample should include members from various community sectors such as teachers, community leaders, students, church personnel, middle and working class, children and politicians as well as health personnel. The results should include qualitative data from subjects' responses.
3. To judge whether increased tolerance would lead to acceptance of the mentally ill. Observations would need to be conducted of local residents' behaviour toward former psychiatric patients in various community facilities such as the public house, local shops,

local clubs, etc. This research project may encounter difficulties in observing spontaneous interactions between patients and members of the public.

4. Local ethnic minority groups' attitudes should be identified to find out whether or not they differ from the white members of the population. This could be carried out by translating the present questionnaire into various local languages, and training interviewers who are able to use these local languages.

5. Repertory grid technique proved to be a useful method in measuring the quantitative changes in public attitudes. This measure should be used with a larger sample size than the number of elements and constructs, and following the same strategy.

6. The results of the study showed that contact with mentally ill is not enough to change attitudes. A research project to measure changes in public attitudes is crucial. This could be conducted by using the questionnaire as above, then design an educational programme according to the local residents' needs including the local minorities groups. Afterwards apply the same questionnaire to the same sample to identify changes. A control group not receiving education would be an essential element in the design.

7. Projects to educate the public should be targeting smaller groups rather than large communities. The design of the project should be directed towards members of the local residents who expressed willingness to help and support former psychiatric patients as well as those who are neutral in their views. Staff members of various community mental health facilities are in a good position to influence public opinions over a long term through interaction with the public.

8. Research project to teach patients social skills to increase their level of integration in their local community. This could be done by identifying their social skills needs using observation scales with staff members. This should be followed by role play exercises at the facilities for various social interactions with the public for example, buying things from the shops, eating in public places etc., then encourage patients to use those skills in real situations. Then, repeating the same scales on several occasions.

9. Replication of the staff study on a wider scale, that is to say large numbers in various community settings. To ensure the reliability of the results a control group from hospital staff may be used and the data should be collected over an extended time period, for example interviewing the staff after one year. This project would allow analysis of the data in a quantitative form, identifying the effect of the policy of various districts on staff roles, developing a programme of training that is suitable to staff's needs in the community.

8. REFERENCES

REFERENCES

ABRAHAMSON, D. (1985) The Social Network of Patients Moving From Hospital into the Community Paper to Symposium Kings Fund Centre, London.

ADAMS-WEBBER J.(1979) *Personal Construct Theory Concepts and Applications.* Chichester: John Wiley and Sons.

ADAMS-WEBBER, J. (1980) Differences between Physical and Psychological Constructs in Repertory Grids. *British Journal of Medical Psychology,* 53:319-322.

AGNEW, J. & BANNISTER, D. (1973) Psychiatric Diagnosis as a Psudo-Specialist Language. *British Journal of Medical Psychology,* 46:69-73.

AJZEN, I. & FISHBEIN, M. (1980) *Understanding Attitudes and Predicting Social Behavior.* New Jersey: Prentice-Hall, Inc., Englewood Cliffs.

ALLEN, J. & BARTON,G. (1976) Patient Comments About Hospitalization: Implications for Change. *Comprehensive Psychiatry,* 17:631-640.

ALLAN, G. (1979) *A Sociology of Friendship and Kinship.* London, George Allen & Unwin.

ALLPORT, G. (1954) *The Nature of Prejudice.* New York. Addison-Wesley Publishing Company.

ALTROCCHI, J. & EISDOFER, C. (1961) Changes in Attitudes Towards Mental Illness. *Mental Hygiene,* 45: 563-570.

ANDREWS, G., TEESSON, M., STEWART, G. & HOULT, J. (1990) Follow-Up of Community Placement of the Chronic Mentally Ill in New South Wales. *Hospital and Community Psychiatry,* 41 (2): 184-188.

ANTONY, A. & MARGULRES, A. (1974) Rehabilitation Counselling: A Decisive Approach. *Journal of Rehabilitation,* 40(3):18-20.

ASSOCIATION OF COUNTY COUNCILS (1985) Strategies for Community Care, London: ACC.

ATKINSON, J. (1971) *A Handbook for Interviewers.* Office of Population Censuses & Surveys. Social Survey Division. London, Her Majesty's Stationary.

AVIRAM, U. (1990) Community Care of the Seriously Mentally Ill: Continuing Problems and Current Issues. *Community Mental Health Journal,* 26(1):69-88.

BACHRACH, L. (1980) Is the Least Restrictive Environment Always the Best? Sociological and Semantic Implications. *Hospital and Community Psychiatry,* 31(2): 79-103.

BACHRACH, L. (1983) *Deinstitutionalization.* Jossey Bass Inc.: San Francisco, London.

BACHRACH, L. (1984) Asylum and Chronically Ill Psychiatric Patients. *American Journal of Psychiatry,* 141(8): 975-978.

BACHRACH, L. (1988) Programs and Politics: Toward New Coalitions. *Hospital and Community Psychiatry,* 39(9): 927-928.

BAKER, F. & INTAGLIATA, J. (1982) Quality of life in the Evaluation of Community Support Systems. *Evaluation & Program Planning,* 5:69-79.

BARON, R. (1981) Changing Public Attitudes About the Mentally Ill in the Community. *Hospital and Community Psychiatry,* 32:173-178.

BARTON, R. (1976) *Institutional Neurosis,* (3rd ed.). Bristol. John Wright & Sons.

BEAIL, N. (1984) Consensus Grids: What About the Varience? *The British Journal of Medical Psychology,* 57(2):193-195.

BECKER, H. (1963) *Outsiders : Studies in the Sociology of Deviance.* New York: Free Press.

BELSON, W.(1957) "The Hurt Mind". B.B.C. Audience. Research Report.

BENTZ, K. & EDGERTON, W. (1971) The Consequences of Labelling a Person as Mentally Ill. *Social Psychiatry,* 6(1): 29-33.

BENTEZ, W., EDGERTON, J. & KHERBIAN, M. (1969) Perceptions of Mental Illness among People in a Rural Area. *Mental Hygiene,* 53:459.

BERKOWTZ, R., EBERLEIN_FRIES, R., KUIPERS, L.& LEFF, J. (1984) Educating Relatives About Schizophrenia. *Schizophrenia Bulleten,* 10(3):418-428.

BERNADT, M. (1990) After the Asylums. *British Medical Journal,* 5:1274.

BLIZARD, P. (1968) Public Images of the Mentally Ill in New Zealand. *New Zealand Medical Journal,* (11): 297-303.

BLIZARD, P. (1970) The Social Rejection of the Alcoholic and the Mentally Ill in New Zealand. *Social Science and Medicine,* 4: 513-526.

BLUM, R & DOWNING, J. (1964) Staff Response To Innovation in a Mental Health Service. *American Journal of Public Health,* 54(8):1230-1240.

BOARD, R. (1971) Rejection of the Mentally Ill Continuities and Further Development. *Social Problems,* 18: 496-509.

BOLLINI, P. & MOLLICA, R. (1989) Surviving Without the Asylum: An Overview of the Studies on the Italian Reform Movement. *Journal of Nervous & Mental Disease,* 177(10):607-615.

BOSANQUET, N. (1988) The Ailing State of National Health. In Jowell, R (Ed.) *British Social Attitudes:* The 5th Report. Sharon Witherspoon and Lindsay Brook. Gower.

BOWEN, W., TWEMLOW, S. & BOQUET, R. (1978) Assessing Community Attitudes towards Mental Illness. *Hospital and Community Psychiatry,* 29(4):251-253.

BROCKMA, J., DARCY, C. & EDMONDS, L. (1979) Fact or Artifacts? Changing Public Attitudes towards the Mentally Ill. *Social Science and Medicine,* 13A(6): 673-682.

BRUGHA, T., WING, J. & SMITH, B. (1989) Physical Health of the Long-Term Mentally Ill in the community. Is There Unmet Need? *British Journal of Psychiatry.* 155(12): 777-781.

BUDSON, R. & JOLLEY, R. (1978) A Crucial Factor in Community Program Success: The extended Psychosocial Kinship System. *Schizophrenia Bulletin*, 4:609-621.

BULMER, M. (1986) *Neighbours: The Work of Philip Abroms.* Cambridge. Cambridge Univeristy Press.

CARSTAIRS, G. & WING, J. (1958) Attitudes of the General Public to Mental Illness. *British Medical Journal*, 6(9): 594-597.

CHAN, F., HEDL, J. PARKER, H., LAM, C., CHAN, T. & YU, B. (1988) Differential Attitudes of Chinese Students Towards People with Disabilities: A Cross-Cultural Perspective. *The International Journal of Social Psychiatry,* 34(4):267-273.

CHESLER, M. (1965) Ethnocentrism & Attitudes Toward the Physically Disabled *Journal of Personality & Social Psychology,* 2:877-82.

CHUNG, F. (1990) People Against the Mentally Ill:Community oppositionto Residential Treatment Facilities. *Community Mental Health Journal,* 26(2):205-212.

COHEN, C. & SOKOLOVSKY, J. (1978) Schizophrenia and Social Networks: Ex-patients in the Inner City. *Schizophrenia Bulletin*, 4:546-552.

COLLIN , J. (1987) Managing People in Change. Some Implications of the Transition from Hospital to Community Care. *Hospital & Health Services Review,*7:162-164.

COTMACK, D. (1981) Psychiatric Nursing Described. An Investigation of the Role of the Psychiatric Nurse Using Flanagan's Critical Incident Technique. PhD. Dundee College of Technology. CNAA.

CRAWFORD, F., ROLLINS, G. & SUTHERLAND, R. (1960) Variations Between Negroes & Whites in Concepts of Mental Illnes & its Treatment. *Academic Science,* 84:918-937.

CREPET, P. (1990) A Transition Period in Psychiatric Care in Italy Ten Years After the Reform. *British Journal of Psychiatry*, 156(1):27-36.

CROCETTI, G. & LEMKAU, P. (1962) Communications On Rejection of the Mentally Ill. *American Journal of Psychiatry*, 118: 577-578.

CROCETTI, G. & LEMKAU, P. (1963) Public Opinion of Psychiatric Home Care . *American Journal of Public Health*, 53(3):409- 417.

CROCETTI, G. HERZL, R. & SSIASSI, I.(1971) Are the Ranks Closed? Attitudinal Social Distance & Mental Illness. *American Journal of Psychiatry*, 127:11221-1127.

CROCETTI, G. & SPIRO, P. LEMKAU, P. (1972) Multiple Models & Mental Illness: A Rejoinder to Failure of Moral Enterprise: Attitudes of the Public to Mental Illness by T.R. SARBIN & J. MANCUSO. *Journal of Counselling & Clinical Psychology,* 39:1-5.

CROCETTI, G. SPIRO, H. & SIASSI, I. (1974) *Contemporary Attitudes towards Mental Illness*. London: University of Pittsburgh Press.

CROMWELL, R. & CALDWELL, D. (1962) A Comparison of Ratings Based on Personnal Construct's of Self and Others. *Journal of Clinical Psychology*, 18:43-36.

CROCKETT, W. (1965) Cognitive Complexity and Impression Formation In Maher,B. (ed.) *Progression Experimental Personality Research*. Vol 2. New York. Academic Press.

CRUMPTON, E. & WING, D. (1965) Conceptions of Normality and Mental Illness Held by Normal and Schizophrenic Adults. *Psychiatry Digest*, 26(5): 39-43.

CUMMING, E. & CUMMING, J. (1957) *Closed Ranks: An Experiment in Mental Health Education.* Harvard University Press.

DAVIDSON, L. (1990) Learning to Change. *Openmind*, 14 April:5-15

DAVIS, J. FREEMAN, H. & SIMMON, O. (1957) Rehospitalization and Performance Level Among Former Mental Patients. *Social Problems,* 5:37-44.

DAVIS, N. (1972) Labelling Theory in Deviance Research. *Sociological Quarterly*,13: Fall, 447-474.

DEAR, M., FINCHER, R. & CURRIE, L. (1977) Measuring the External Effects of Public Programme. *Environment Planning*, Part 9, 137-147.

DEAR, M. & TAYLOR, S. (1982) *Not on our Street. Community Attitudes to Mental Health Care*. London: Pion Limited.

DEPARTMENT OF EDUCATION AND SCIENCE (1986) Working Together-Education and Training, Cmnd 9823 London: HMSO.

DEVELOPMENT SERVICES for PEOPLE WITH SEVERE LONG-TERM MENTAL HEALTH PROBLEMS in EXETER CITY (1987) Report for Exeter Health Authority by McAusland,T., Patel,Y.& Ayling,E.

DENZIN, N. (1970) Strategies of Multiple Triangulation in Denzin, N.(ed.) *The Research Act.* New York:McGraw-Hill.

DHSS (1975) Better Services for the Mentally Ill, CMND 6233. London:HMSO.

DHSS (1989) Care in the Community. A Consultative Document on Moving Resources for Care in England. HC(81)9/LAC(81)5. London: DHSS.

DOHRENWEND, B., BERNARD, V. & KOLB, L. (1962) The Orientation of Leaders in an Urban Area Toward Problems of Mental Illness. *American Journal of Psychiatry,* 118:683-691.

DOHRENWEND, S. and CHIN-SHONG, E. (1967) Social Status and Attitudes Towards Psychological Disorders: The Problem of Tolerance of Deviance. *American Sociological Review,* 32:417-433.

DOWNEY, K. (1967) Public Image of Mental Illness. A Factor Analytic Study of Causes and Symptoms. *Social Science & Medicine,* 1:45-65.

DRAKE, R. & WALLACH, M. (1988) Mental Patients' Attitudes Toward Hospitalisation: A Neglected Aspect of Hospital Tenure. *American Journal of Psychiatry,* 145:29-34.

DUFFY, L. (1987) Methodological Triangulation : A Vehicle for Merging Quantitative and Qualitative Research Methods. Image : *Journal of Nursing Scholarship,* 19(3): 23-28.

ECHLIN, R.,ELHERINGTON, S., KINGSLEY, S. SMITH,H. & TOWELL,D. (1990) Managing Psychiatric Services in Transition- Working Paper NO.7, Londond, King's Fund.

EDGERTON, W. & BENTZ, W. (1969) Attitudes and Opinions of Rural People about Mental Illness and Program Services. *American Journal of Public Health,* 470-477.

EHRLICH, H. (1973) *The Social Psychology of Prejudice.* Wiley-Interscience. New York: John Wiley & Sons.

EKDAWI, M. (1987) National Demonstration Services - Statement on Psychiatric Rehabilitation and Care in the Community. *Bulletin of the Royal College of Psychiatrists,* 11: 207-209.

EKDAWI, M. (1989) Work at Netherne - A Service Responding to Change. *Bulletin of the Royal College of Psychiatrists,* 13:30-32.

ELLIS, A. (1967) Should Some People be Labeled Mentally Ill? *Journal of Consulting Psychology,* 31:435-446.

ELINSON, J., PADILLA, E. & PERKINS, M. (1967) Public Image of Mental Health Services, USA: Mental Health Materials Center Inc.

ELLSWORTH, R. (1965) A Behavioural Study of Staff Attitudes toward Mental Illness. *Journal of Abnormal Psychology,* 70(3): 194-200.

FAGIN, L. (1985) Deinstitutionalization in the USA. *Bulletin of the Royal College of Psychiatrists,* 9(6):*Abnormal Psychology,* 87(2): 272-279.

FALLOON, I., SHANAHAN, W. (1990) Community Management of Schizophrenia. *British Journal of Psychiatry,* 43(1): 62-66.

FARINA, A., ALLEN, J., & SAUL, B. (1968) The Role of the Stigmatized Person in Affecting Social Relationship. *Journal of Personality and Social Psychology*, 36: 169-182.

FELCE, D., DEKOCK, U., THOMAS, M. & SAXBY, A. (1986) Change in Adaptive Behaviour of Severely and Profoundly Mentally Handicapped Adult in Different Residential Settings. *British Journal of Psychology*, 77:489-501.

FERNANDO, M., VELAMOOR, V., COOPER, A. & CERNOVSKY, Z. (1990) Some Factors Relating to Satisfactory Postdischarge Community Maintenance of Chronic Psychiatric Patients. *Canadian Journal of Psychiatry*, 35(1):71-73.

FLETCHER, R. (1969) Measuring Community Mental Health Attitudes by means of Hypothetical Case Descriptions. *Social Psychiatry*, 4(4): 152-156.

FOURNET, G. (1967) Cultural Correlates with Attitudes, Perception Kowledge and Reported Incidence of Mental Disorders. Ph.D Thesis, Louisiana State University Agricultural and Mechanical College.

FRACCHIA, J., CANATE, D., CAMBRIA, E., RUEST, E., & SHEPPARD, C.(1976) Public Views of Ex-Mental Patients : A Note on Perceived Dangerousness and Unpredictability. *Psychological Reports*, 38: 495-498.

FRANSELLA, F. (1970)"..And Then There was one" Contribution to Prespectives in *Personal Constructs Theory* in Bannister,D.(ed.). Academic Press. London.

FRANSELLA, F. & JOYSTON-BECHAL, M. (1971) An investigation of Conceptual Process and Pattern Change in Psychotherapy Group. *British Journal of Psychiatry*, 119:199-206.

FRANSELLA, F. & BANNISTER, D.(1977) *A Manual for Repertory Grid Technique.* London. Academic Press.

FREEMAN, H. & KASSEBAUM, R.(1960) Relationship of Education and Knowledge to Opinions About Mental Illness. *Mental Hygiene*, 1:47.

FREEMAN, H. & SIMMON, S. (1963) *The Patient Comes Homes.* New York, John Willey & Sons.

FRIEDSON, E. (1970) *Profession of Medicine. A Study of The Sociology of Applied Knowledge.* New York. Dood. Med.

FURNHAM, A. & REES, J. (1988) Lay Theories of Schizophrenia. *The International Journal of Social Psychiatry,* 34(3): 212-221.

FURNHAM. A. & PENDRED, J. (1988) Attitudes Towards the Mentally and Physically Disabled. *British Journal of Medical Psychology,* 56: 179-187.

GATHERER, A. & REID, J. (1963) Public Attitudes and Mental Health Project. Published by Northamptonshire County Council.

GELB, L. (1980) Overview. Attitudes Toward the Mentally Ill. Research Prespectives. Report of ANVIMH Workshop, January 24-25.

GERBNER, G. (1980) Stigma: Social Functions of the Portrayal of Mental Illness in the Massss Media. Paper Presented atthe Workshop on Research on Stigma Toward the Mentally Ill at the National Institute of Mental Health.

GLAZER, W., SHOLOMSKAS, D., WILLIAMS, D. & WEISSMAN, M. (1982) Chronic Schizophrenics in the Community - Are They Able to Report Their Self-Adjustment? *American Journal of Orthopsychiatry,* 52(1):166-171.

GODBER, G. (1964) "Helping the Family" A Conference Proceeding. The Royal College of Nursing. London.

GOFFMAN, E.(1961) *Asylums: Essays on the Social Situation of Mental Patients and Others Inmates.* New York. Anchor Books.

GOFFMAN, E. (1963) *Stigma.* Englewood Cliffs. N.J. Prentice-Hall.

GOFFMAN, I. (1968) *The Moral Carrer of the Mental Patient in Asylums.* Pelican, Harmonds worth.

GOLDBERG, D., BRIDGES, K., COOPER, W., HYDE, C., STERLING, C. & WYATT, R. (1985) Douglas House: a New Type of Hostel for Chronic Psychiatric Patients. *British Journal of Psychiatry,* 147:383-388.

GOLDMAN, A. (1965) Wanting to Leave or Stay in a Mental Hospital. Incidence & Correlate. *Journal of Clinical Psychology,* 21:317-322.

GOLDSTEIN, K. & BLACKMAN, S. (1975) Generalizations Regarding Deviant Groups. *Psychological Reports,* 37: 278.

GOLDSTEIN, J. & CATON, C. (1983) The Effect of the Community Environment on Chronic Psychiatric Patients. *Psychological Medicine,* 13:193-196.

GOMES-SCHWARTZ, B.(1978) A Modification of Schizophrenic Behavior. *Behavior Modification,* 3:439-468.

GOVE, W. (1970) Societal Reaction as an Explanation of Mental Illness. An Evaluation. *American Sociological Review,* 35: 873-884.

GOVE, W., FAIN,T. & NASHVILL, T. (1973) The Stigma of Mental Hospitalization. *Archives of General Psychiatry,* 28(4):494-500.

GOVE, W. & HOWELL, P. (1974) Individual Resources and Mental Hospitalization: Acomparison and Evaluation of the Societal Reaction and Psychiatric Perspectives. *American Review,* 2:86-100.

GREEN, D. McCORMICK, I. WALKEY. F. & TAYLOR, A. (1987) Community Attitudes to Mental Illness in New Zealand Twenty-two Years On. *Sociological Science Medicine,* 14(5):417-422.

GREENBAUM, J. & WANG, D. (1965) A Senmantic Differential Study of the Concept of Mental Retardation. *Journal of General Psychology,* 73:257-272.

GREENBLATT, M. & GLAZIER, E. (1975) The Phasing Out of Mental Hospitals in the US. *American Journal of Psychiatry,* 132(11):1135-1140.

GRIFFITHS, R. (1974) Rehabilitation of Chronic Psychotic Patients. An Assessment of their Psychological Handicap, An Evaluation of the Effectiveness of Rehabilition, and Observations of the Factors which Predict Outcome. *Psychological Medicine,* 4:316-325.

GURIN, G., VEROFF, J. & FIELD, S. (1960) *American View Their Mental Health.* New York. Basic Books.

HALL, J. (1980) Ward Rating Scales for Long-Stay Patients: A review. *Psyhological Medicine,* 10:277-288.

HALPERT, H. (1969) Public Acceptance of the Mentally Ill. An Exploration of Attitudes. *Public Health Reports,* 84(1):59-64.

HAMILTON, N. (1989) Social Network and Negative versus Positive Symptoms of Schizophrenia. *Schizophrnia Bulletin,* 15(4):625-633.

HARDING, S. (1988) Trends in Permissiveness. In Jowell,R.: *British Social Attitudes.* Fifth Report. Sharon Witherspoon and Lindsay. Brook Gower.

HAMILTON, M. & HOENING, J. (1966) The Exteramural Services and the Mental Hospital. *Medical Care,* 4:189.

HARIZON HOUSE INSTITUTE (1975) Community Careers. An Assessment of the Life Adjustment of former Mental Hospital Patients. Philadelphia. Harizon House Institute.

HAVEMAN, M. (1989) Possibilities in the Management of Long-term Patients Outside the Psychiatric Hospital; Clinical Assessment by the Treatment Staff in The Netherlands.*Psychiatric-Prax,* 16(6):207-213.

HAYS, W. (1973) *Statistics for the Social Sciences* (2nd ed.). New York, Holt, Rinehart & Winston,Inc.

HAZLETON, N., MANDELL, D., & STERN, S.(1975) *Community Care for the Mentally Ill: The Santa Clara County Experience. Health Education Section.* Office of Communications. California. State Department of Health.

HELLER, P. CHALFONT, P. WORLEY, M. QUESADA, G. & BRADFIELD. (1980) Socio-economic Class, Classification of Abnormal Behaviour and Perceptions of Mental Health Care: A Cross-Cultural Comparison. *British Journal of Medical Psychology,* 53:343-348.

HENDRICKS, L., HOWARD, C. and GARY,L.(1981) Help-Seeking Behaviour Among Urban Black Adults. *Social Work,* 26:161-163.

HOLLINGSHEAD, W. & REDLIGH, F.(1958) Social Changes and Mental Illness. New York, John Wiley

HOLLOWAY, F. (1985) Deinstitutionalisation in the USA. Bulletin of the *Royal College of Psychiatrist*, 9:204-5.

HOLMES, P. (1968) Discussion of Dr Lemkau's paper Social Psychiatry

ZUBIN, J. & FREYHAM. F.: *Grune and Stratton.* New York.

HOLMES, D. (1968) *Changes in Attitudes About Mental Illness.* New York:Centre for Communty Research.

HOLTON, W., KRANE, B. & NEWI, P.(1973) Locational Process: Guidelines for Locating Mental Health Services. *Community Mental Health Journal*, 9: 270-280.

HOLZBERG, J. & GEWIRTZ, H. (1963) A Method of Altering Attitudes Toward Mental Illness. *Psychiatric Quarterly,* 37(1):56-61.

HOMANS, G. (1961) *Social Behaviour:Its Elementary forms.* London. Routledge & Kegan Paul.

HULL, J. & THOMPSON, J. (1981) Predicting Adaptive Functioning Among Mentally Ill Persons in Community Settings. *American Journal of Community Psychology*, 9(3): 247-268.

HUSEK, T. & BOBREN, H. (1964) The Relative Importance of Labels and Behaviour Description in Determining Attitudes Toward Labelled Behaviour. *The Psychological Record*, 14: 319-325.

HUXLEY, P. (1986) Quality Measurement in Mental Health Services: A Discussion Paper on Quality of Life Measurement. Good Practice in Mental Health.

JACO, E. (1954) The Social Isolation Hypothesis and Schizophrenia. *American Sociological Review*, 19:567-577.

JALALI, B. JALALI, M. and TURNER, F. (1978) Attitudes Toward Mental Illness. *The Journal of Nervous and Mental Disease*, 166(10): 692-700.

KELLY, G. (1969) *Clinical Psychology and Personality:The Selected Papers of George Kelly* (ed.) Maher, B. New York, Wiley.

KEY, A. & LEGG, C. (1986) *Discharged to the Community. A review of Housing and Support in London for People Leaving Psychiatric Care*. Housing Resarch Gory. The City University.

JICK, T. (1984) Mixing Qualitative and Quantitative Methods. Triangulation in Action. In Maanen, J.: *Qualitative Methodology*. Beverley Hills. Sage Publications.

JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH (1961) Action for Mental Health. New York. Basic Books.

JOHANNSEN, W. (1969) Attitudes Towards Mental Patients. A Review of Empirical Research. *Mental Hygiene*, 53(2):218-228.

JONES, M. (1982) *The process of Change*. London. Routledge & Kegan Paul.

JONES, E., FARINA, A., ALBERT, H., MARKUR, H., DALE, I. & ROBERT,A. (1984) *Social Stigma: The Psychology of Marked Relationships*. New York. Freeman & Company.

JONES, M. (1975) Community care for Chronic Mental Patients: the Need for a Reassessment. *Hospital and Community Psychiatry*, 26: 94-98.

KELLY, G. (1955) *The Psychology of Personal Constructs*. New York. Norton.

KELLY, G. (1963) *A Theory of Personality. The Psychology of Personal Constructs*. New York. W.W.Norton and Company.

KENDELL, R., COOPER, J., GOURLEY, A. & GPELAND, J.(1971) Diagnosis Criteria of American and British Psychiatrists. *Archives of General Psychiatry*, 25:123-130.

KINGDOM, D. (1991) Replacing the Mental Hospital-Community Provision for a District's Chronically Psychiatrically Disabled in Domestic Environments? *British Journal of Psychiatry,* 158(1):113-117.

KIRK, S. (1974) The Impact of Labeling on Rejection of the Mentally Ill: An Experimental Study. *Journal of Health and Social Behaviour,* 15(6):108-117.

KIRK, C. (1987) Half-Way to Independnce. *Community Care,* 12:32-34.

KITSUSE, J. (1962) Societal Reaction to Deviant Behaviour. Problems of Theory and Method. *Social Problems,* 9(3): 247-256.

KRAMER, L. (1965) Links and bariers Between Hospital and Community. *Community Mental Health Journal,* 1(1):16-20

KRAMER, M. (1971) The Internalisation of the Social roles in Institutionalised Chronic Mental Patients. *Journal of Health & Social Behaviour,7:32-37.*

KRAUSS, J. & SLAVINSKY, A. (1982) *The Chronically Ill Psychiatric Patient and the Community.* London. Blackwell Scientific Publications.

KORMAN, N. & GLENNERSTER, H. (1990) Hospital Closure. A Political and Economic Study. Milton Keynes, Open University Press.

LAMB, H. & GOERTZEL, V. (1971) : Discharged Mental Patients are they Really in the Community? *Archives General Psychiatry,* 24(1): 29-34.

LAMB, H. & GOERTZEL, V. (1977) The Long-term Patients in the Era of Community Treatment. *Archives of General Psychiatry,* 34: 679-682.

LAMB, H. (1979) Roots of Neglect of the Long-term Mentally Ill. *Psychiatry,* 42:201-207.

LAMB, H. (1979) The New Asylums in the Community. *Archives General Psychiatry,* 37:135-137.

LAMB, H. (1981) What did we Really Expect from Deinstitutionalisation? *Hospital and Community Psychiatry,* 32(2):105-109.

LEAF, P., LIVINSTON, M., TISCHLER, G., WEISSMAN, M., HOLZER,G. & MYERS, J. (1985) Contact with Health Professionals for the Treatment of Mental or emotional Problems. *Medical Care,* 23:1322-1337.

LAINE, A. & LEHTINEN, V. (1973) Attitudes Towards Mental Illness and their Relationship to Structure and Mental Hospital Bed Utilization in Two Finish Rural Communities. Social Psychiatry, 8:117-123.

LAU, G. (1990) Closing Time. *Nursing Times*, 30 May, 86(22):40-42.

LAZARUS, R. (1966) *Psychological Stress and the Coping Process.* New York, McGraw-Hill.

LEAF, P. BRUCE, M. TISCHLER, G. & HOLZA, C. (1987) The Relationship Between Demographic Factors and Attitudes toward Mental Health Services. *Journal of Community Psychology*, 15(4): 275-284.

LEAF, P. BRUCE, M. & TSICHLER, G. (1986) The Differential Effect of Attitudes on the Use of Mental Health Services. *Social Psychiatry,* 21: 187-192.

LEHMANN, S. JOY, V., KREISMAN, D. & SIMMENS, S. (1976) Responses to Viewing Symptomatic Behaviours and Labelling of Prior Mental Illness. *Journal of Community Psychology,* 4:327-334.

LEHMAN, A., REED, S. & POSSIDENTE, S.(1982) Priorities for Long Term Care: Comments from Board and Care Residents. *Psychiatric Quarterly*, 54:181-189.

LEHMAN, A. (1983) The Well-being of Chronic Mental Patients. Assessing Their Quality of Life. *Archives of General Psychiatry,* 40: 369-373.

LEHMAN, A., POSSIDENTE, S., & HAWKER, F. (1986) The Quality of Life of Chronic Patients in A State Hospital and Community Residences. *Hospital and Community Psychiatry,* 37:901-907.

LEHTINEN, V. & VAISANEN, E. (1978) Attitudes Towards Mental Illness and Utilization of Psychiatric Treatment. *Social Psychiatry,* 13(2): 63-68.

LEMERT, E. (1967) *Human Deviance, Social Problems and Social Control.* Englewood Cliffs. Prentichall.

LEMKAU, P. & CROCETTI, G. (1962) An Urban Population's Opinion and Knowledge About Mental Illness. *American Journal of Psychiatry,* 118:692-700.

LEMKAU, P. (1968) *Evaluation of the Effect of Changes in Environmental Factors with Special Attention to Public Attitudes Toward Mental Health and Mental Illness. Social Psychiatry.* ZUBIN, J.& FREYHAM, F.(ed.): New York. Grune and Stratton.

LEVINE, D. (1972) A Cross-National Study of Attitudes Toward Mental Illnes. *Journal of Abnormal Psychology,* 80(2): 111-114.

LEWIN, K. (1951) *Field Theory in Social Science.* New York. Harper & Brothers.

LINSKY, A. (1970) Community Homogeneity and Exclusion of the Mentally Ill. Rejection Versus Concensus About Deviance. *Journal of Health and Social Behaviour,* 11: 304-311.

LINSKY, A. (1970) Who Shall be Excluded: The Influence of Personal Attributes. Social *Psychiatry,* 5(3):166-171.

LINK, B. (1987) Understanding Labelling Effects in the Area of Mental Disorders: An Assessment of the Effects of Expectation. *American Sociological Review,* 52(2):96-112.

LINK, B. & CULLEN, F. (1986) Contact with the Mentally Ill and Perceptions of how Dangerous they are. *Journal Health and Social Behaviour,* 27(4): 289-302.

LINK, B., CULLEN, F., FRANK, J. & WOZNIAK, J. (1987) The Social Rejection of Former Mental Patients : Understanding why Labels Matter. *American Journal Sociology,* 92(6):1461-1501.

LINK, B. & CULLEN, T. (1983) Reconsidering the Social Rejection of Ex-Mental Patients: Levels of Attitudinal Responses. *American Journal of Community, Psychology,* 11:261-273.

LIVINGSTON M. & DRYSON, A. (1989) The Glasgow Rehabilitation Survey. *British Journal of Psychiatry,* 154: 620-624.

LOAM, O. & EGAN, M. (1990) Public Perceptions of Psychiatric Services. *Nursing Times,* 86(28):56.

LOCKER, D., RAO, B. & WEDDELL, J. (1979) The Community Reaction to a Hostel for the Mentally Handicapped. Unpublished report submitted to L'ANCHE Lambeth Committee.

LONGABOUGH, R., ELDRED, S., BELL, N. & SHERMAN, L. (1966) The International World of the Chronic Schizophrenic Patient. *Psychiatry,* 29:78-99.

LOWMAN, A. (1976) Rejection of the Mentally Ill : An Experiments in Labelling. *The Sociological Quarterly,* 17 Autumn, 14: 555-560.

LYNCH, V., BUDSON, R. & JOLLEY, R. (1977) Meeting the Needs of Former Residents of a Half Way House. *Hospital and Community Psychiatry,* 25: 585-90.

MACINICK, C. (1990) Strategies for Burnout Prevention in the Mental Health Setting. *International Nurse Review,* 37(2):247-249.

MACKAY, R. (1969) Personal Concepts of the Mentally Ill Among Care giving Groups. *Mental Hygiene,* 53: 245-252.

MAIR, J. (1964) The Drivation. Reliability and Validity of Grid Measures, some *Problems and Suggestions,* 17(55) 7A.

MAISEL, A. (1951) When Would You Consult a Psychiatrist? *Colliers',* 12:12-15.

MALM, U., MAY, P. & DENCKER, S. (1981) Evaluation of the Quality of Life of the Schizophrenic Outpatient : A checklist. *Schizophrenia Bulletin,* 7(3): 477-483.

MAINS, J., HUNT, C., BRAWER, M. & KERCHERT, L. (1965) Public and Psychiatric Conceptions of Mental Illness. *Journal of Health & Human Behaviour,* 6:48-55.

MAINS, J., HUNT, C. BRAWER, M. & KERCHERT, L. (1989) Public and Psychiatric Conceptions of Mental Illness. *Journal of Health and Human Behaviour,* 6:48-55.

MAINS, S. MISHLER, S. AYERS, B., POPPA, L. & JONES, T. (1989) Easing Transitions in Care Deliveeery with a Core Training Group. *Nursing Connections,* 4:5-15.

MARION, W. & GRABSKI, D. (1979) An Assessment of a Continuing Care Program.*Hospital and Community Psychiatry,* 30(6):393-395.

MARKET OPENION & RESEARCH INTERNATIONAL (MORI) (1979) Mental Illness-Public and Business Attitudes. London. Research Study onducted for The Mental Health Appeal.

MARKET OPINION & RESEARCH INTERNATIONAL (MORI) (1982) *Neighbours:* Computer Tables. London.

MARGOLIS, B., KROES, W. & QUINN, R. (1974) Job Stress: An Unlimited Occupational Hazard. *Journal of Occupationa and Medicine,* 16:654.

MATAS, M., EL.GUEBALY, N. PETERKIN, A. GREEN, M. & HARPER, D. (1985) Mental Illness and the Media. *Canadian Journalof Psychiatry,* 30(1): 12-17.

McGAHAN, P. (1972) The Neighbour Role and Neighbouring in a Highly Urban Area. *Sociological Quarterly,* 13: 397-408.

MILLER, D. & DAWSON, W. (1965) Effects of Stigma on re-employment of Mental Patients. *Mental Hygiene,* 49:281-287.

MILLER, R. & RIESSMAN, F.(1968) *Social Class and Social Policy.* New York. Basic Books.

MILLER, R. (1979) The Psychiatrist as Public Defender. *Psychiatric Opinion,* 16:3334-36.

MILLER, A. (ed.) *In the Eye of Beholder. Contemporary Issues in Stereotyping.* Miami University. Praeger Special Studies, Praeger Scientific.

MILLER, R. (1982) The Least Restrictive Alternative. *Community Mental Health Journal*, 18 Spring, 46-55.

MITCHELL, J. (1969) *The Concept and Use of Social Network.* Mitchell,J. (ed.), Social Networks in Urban Situations, Manchester, England. University Press.

MITCHLL, E. (1986) Multiple Trangulation: a Methodology for Nursing Science. *Advanced in Nursing Science,* 8(3):18-26.

MINISTRY OF HEALTH (1963) "Health and Welfare- The Development of Community Care". London: MHSO.

MINISTRY OF HEALTH (1964) Report of a Joint Committee of The Central and Scotish Health Services Council on Health Education. London:HMSO.

MINISTRY OF HEALTH (1964) Health Education Report of a Joint Committee of the Central and Scottish Health Services Councils. Her Majesty's Stationery Office. London.

MOOR, D. (1988) An Investigation Into Stress In Psychiatric Nursing. MSC. Thesis. Occupational Psychology of the CNAA. Hartfield Polytechnic.

MOSHER, L. (1983) Recent Development in the Care, Treatment and Rehabilitation of the chronic Mentally Ill in Italy. *Hospital and Community Psychiatry,* 34(10): 947-950.

MOSHER, L. (1983) Radical Deinstitutionalization: the Italian Experience. *International Journal of Mental Health,* 11(4): 129-136.

MULFORD, C. (1968) Ethnocentrism and Attitudes Toward the Mentally Ill. Notes and Commentaries. *The Sociological Quarterly,* 9: 107-111.

MURPHY, J. (1976) Psychiatric Labelling in Cross Cultural Perspective. *Perspective Science,* 191: 1019-1028.

MYER, J. (1964) Attitudes Towards Mental Illness In a Maryland Community. Public *Health Reports,* 79: 769-772.

NIERADZIK, K. & COCHRANGE, R. (1981) Public Attitudes Towards Mental Illness - The Effects of Behaviour, Roles and Psychiatric Labels. International *Journal of Social Psychiatry,* 31: 23-33.

NUNNALLY, J. (1961) *Popular Conception of Mental Health: Their Development and Change.* New York: Holt. Rinehart.

NUNNALLY, J. & OSGOOD, C. (1958) *The Development and Change of Popular Conceptions About Mental Health.* Urbana, Ill:Institute of Communication & Research, University of Illinois.

O'CONNOR, T. & SMITH, P. (1987) Labelling of Schizophrenics by Professionals and Lay-Persons. *British Journal Clinical Psychlogy,* 26: 311-312.

OSGOOD, C., SUCI, G. & TANNENBAUM, P. (1957) *The Measurement of Meaning.* Urbana. University of Illinois Press.

OSGOOD, C. & Suci,G. (1969) *Semantic Differential Technique.* Aldine Publishing Company.

OLMSTED, D. & DURHAM, K. (1976) Stability of Mental Health Attitudes A Semantic Differential Study. *Journal of Health and Social Behaviour,* 17(3):35-44.

OLMSTED, D. & ORDWAY, R. (1963) Concepts of Mental Health. A Pilot Analysis. Final Report to National Institute of Mental Health.

OWENS, D. & JOHNSTONE, E. (1980) The Disabilities of Chronic Schizophrenia. Their Nature and Factors Contributing to their Development. *British Journal of Psychiatry,* 136:384-395.

ORLEY, J. & LEFF, J. (1972) The Eeefect of Psychiatric Education on Attitudes to Illness Among the Ganda. *British Journal of Psychiatry,* 121(561): 137-141.

PARRA, F. (1987) Perceptions of Mental Illness in Mexico. A Descriptive Study in the City of Chihuahua. *The International Journal of Social Psychiatry,* 33(4): 270-276.

PARRISH, A. (1990) Personal View: Working Through the Change. *Nursing,* 4(10):35.

PARSONS, T. (1951) *The Social System.* Glencoe. The Free Press.

PATTISON, E., DERANCISCO, D. WOOD, P. FRAZIER, H. & CROWDER, J.(1975) A Psychosocial Kinship Model for Family Therapy. *American Journal of Psychiatry,* 132: 1246 - 1251.

PENAYO, V., JACOBSSON, L. CALDERA, T. & BERMANN, G. (1988) Community Attitudes and Awareness of Mental Disorders. *Acta Psychiatric Scandivica,* 78:561-566.

PHILIP, A. (1967) Prediction of Successful Rehabilitation by Nurse Rating Scale. *British Journal of Psychiatry,* 134:422-426.

PHILLIPS, D. (1966) Public Identification and Acceptance of the Mentally Ill. *American Journal of Public Health,* 56: 755-763.

PHILLIPS, D. (1964) Rejection of the Mentally Ill. The Influence of Behaviour and Sex. *American Sociological Review,* 29:679-687.

PHILIPS, D. (1963) Rejection: a Possible Consequence of Seeking Help for Mental Disorders. *American Sociological Review,* 28: 963-972.

POLCIN, D. (1990) Administrative Planning in Community Mental Health. *Community Mental Health Journal,* 26(2):181-192.

PRYER, M., DISTEFANO, M. & MARR, L.(1969) Attitude Changes in Psychiatric Attendants Following Experience and Training. *Mental Hygiene,* 53(3):253-257.

RABKIN, J. (1980) Determinants of Public Attitudes About Mental Illness: Summary of the Research Liteature in Rabkin,J., Gelb, L. & J. Lazar (ed.): *Attitudes Toward the Mentally Ill: Research Prespectives.* Washington,DC. US Government Printing Office.

RABKIN, J., GELB, L. & LAZER, J. (1980) Attitudes toward the Mentally Ill: Research Perspectives. Report of an NIMH Workshop. Jan.24-25

RABKIN, J. (1974) Public Attitudes Toward Mental Illness. A Review of the Literature. *Schizophrenia Bulleton,* Fall, 10: 9-33.

RABKIN, J. (1979) Criminal behavior of Discharged Mental Patients: Critical Approach of Research. *Psychological Bulleton,* 86:1-27.

RAHV, M. STRUENING, F. & ANDREWS, H. (1984) Opinions on Mental Illness in Israel. *Social Science and Medicine,* 19(11): 1151-1158.

RAMSEY, G. & SEIPP, M. (1948) Attitudes and Opinions Concerning Mental Illness. *Psychiatric Quarterly,* 22: 428-444.

REICH, R. & SEIGAL, L. (1978) The Emergence of the Bowery as a Psychiatric Dumping Ground. *Psychiatric Quarter2ly,* 50(3):191-201.

RHOADES, L. (1982) Psychosocial Intervention. A Way Out for Chronic Psychiatric Patients. *Hospital & Community Psychiatry,* 33(9):709-710.

RICHARDS, K. (1982) A Mind Disordered: The Public View. *Nursing Mirror,* October 13: 55-56.

ROMAN, P. & TRICE, H. (1967) *Schizophrenia and the Poor.* Ithaca, New York:Cayuga Press.

ROMAN, P. & FLLOYD, H. (1981) Social Acceptance of Psychiatric Illness and Psychiatric Treatment. *Social Psychiatry,* 16:21-29.

ROSS, M. (1962) How to Act Towards Emotionally Disturbed Neighbours, Friends, and Relatives. *Mental Hygiene,* 46:3-10.

ROSEHAM, D. (1973) On Being Sane in Insane Places. *Science,* 179:250-258.

ROSENBERG, G. & ATTINSON,L. (1977) Attitudes Toward Mental Illness in the Working Class. *Social Work in Health Care,* 3(1):77-86.

RUBIN, S. & ROESSLER, R. (1978) Guidelines for Successful Vocational Rehabilitation of the Psychiatrically Disabled. *Rehabilitation Lit,* 39:70-74.

RUESCH, J. & BRODSKY,C. (1968) The Concept of Social Disability. *Archives of General Psychiatry,* 19:394-403.

RUSHING, W. & ESCO, J. (1977) Status Resources and Behavioural Deviance as Contingencies of Societal Reaction. *Social Forces,* 56(1):132-147.

RYLE, A. (1975) *Frames and Cages. The Repertory Grid Approach to Human Understanding.* London, Sussex University Press.

SAAH. S. (1969) Crime and Mental Illness. Some Problems in Defining and Labelling Deviant Behaviour. *Mental Hygiene,* 53(1):21-33.

SARBIN, T. & MANCUSO, J. (1972) Paradingms andMoral Judgements: Improper Conduct is not a Disease. *Journal of Cousalting and Clinical Psychology,* 39:6-8.

SAXBY, H., FELCE, D., HARMAN, M., & REPP, A. (1988) The Maintenance of Client Activity and Staff-Client Interaction in Small Community Houses for Severely and Profound Mentally Handicapped Adults: A Two-Year Follow-Up . *Behavioural Psychotherapy,* 16:189-206.

SCHEFF, J. (1964) The Social Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patient in mid-Western State. *Social Problems,* Spring, 111:401-413.

SCHEFF, T. (1966) *Being Mentally Ill: A Sociological Theory.* Chicago: Aldine.

SCHOOLER, C. (1963) Affiliation Among Schizophrenics: Preferred Characteristics of Other. *Journal Nervous and Mental Disorder,* 117:438-446.

SCHWARTZ, M. & SCHWAAARTEZ, C. (1964) *Social Approaches to Mental Patient Care.* New York. Columbia University Press.

SCHWARTIZ, C., MYERS, J. & ASTRACHAN, B. (1974) Psychiatric Labeling and the Rehabilitation of the Mental Patient. *Achives General Psychiatry,* 31(9):329-334.

SEGAL, S., BAUMOL, J. & JOHNSON, E. (1977) Falling Through The Cracks: Mental Disorder and Social Margin in Young Vagrant Population. *Social Problems,* 24(3):387-400.

SEGAL, S. & MOYLES, E. (1980) Management Style and Institutional Dependency in Sheltered Care. *Social Psychiatry,* 14:159-165.

SEGAL, S. (1980) Neighbourhood Types and Community Reactionto the Mentally Ill. A Paradox of Intensity. *Journal of Health and Social Behaviour,* 21(12):345-359.

SEGAL, S. & BAUMOHL, J. (1980): Engaging the Disengaged: Proposals of Madness and Vagrancy. *Social Work,* 25(5):358-365.

SEGAL, S. & AVIRAM, U. (1980) Assessing Social Integration of Mentally Ill Person in Community Care. *Rehabilitation Brief,* #(5):1-4.

SEGAL, S. & AVIRAM. U. (1978) *The Mentally Ill in Community-Based Sheltered Care. A study of Community Care and Social Integration.* A. Wiley - Interscience Publication. New York. John Wiley and Sons.

SEGAL, S., SILVERMAN, S. & BAUMOHL, J. (1989) Seeking Person-Environment Fit in Community Care Placement. *Journal of Social Issues,* 145(3):49-64.

SELING, M. & JOHNSON, G. (1990) A Bridge to the Community for Extended-Care State Hospital Patients. *Hospital and Community Psychiatry,* 41(2): 180-183.

SIEVEKING, N., DOCTOR, R. (1969) *Students' Attitudes Toward Physical, Psychological and Social Problems.* Proceedings of the 7th Annual Conention of the American Psychological Association, 4:855-856.

SISTER LORETTA MARIA (1965) The Stigma of Mental Illness Can Be Erased. *Mental Hygiene,* 49:46-51.

SLIMMER, L., WENDT, A. & MARTINKUS, S. (1990) Effect of Psychiatric Clinical Learning Site on Nursing Students' attitudes Toward Mental Illness and Psychiatric Nursing. *Journal Nursing Education,* 3(29):127-133.

SHAW, R., HARGREAVES, W., SURBER, R., LUFT, L. & SHADOAN, R.(1990) Continuity and Inensity of Case Management Activity in Three MHCs. *Hospital and Community Psychiatry,* 41(3):323-325.

SHADISH, W., THOMAS, S. & BOOTZIN, R. (1982) Criteria for Success in Deinstitutionalization:Perceptions of Nursing Homes by Different Interest Groups. *American Journal of Community Psychology,* 10(5):553-566.

SERMAN, S, NEWMAN, S. & FRENTEL, E. (1984) Community Acceptance of the Mentally Ill in Foster Family Care. *Health & Social Work,* 9(3):183-199.

SHEPHERD, G. (1983) *Planning the Rehabilitation of the Individual. Theory and Practice of Psychiatric Rehabilitation.* Watts, F. & Bennet D.(eds.) John Wiley & Sons, Ltd.

SHEARER, A. (1983) An Ordinary Life. Project Paper, No.42, London, Kings Fund Publishing Office.

SHPIRO, H., SIASSI, I. & CROCETTI, G. (1974) The Issue of Contact with the Mentally Ill. *American Journal of Public Health,* 64:876-870.

SIASSI, I., SPIRO, H. & CROCETTI, G. (1973) The Social Acceptance of the Ex-Mental Hospital Patient. *Community Mental Health Journal,* 9 (3) 233-243.

SIEGLER, M., CHEEK, F. & OSMOND, H. (1968) Attitudes Towards Naming the Illness. *Mental Hygiene,* 52: 226-238.

SLATER, P. (1967) Notes on Ingrid. Grid Research Unit, St George's Hospital Medical School. London. Vincent Andrew & Company.

SLATER, P. (1972) A Grid Measurement of Consistency in Repertory Grids. British *Journal of Psychiatry,* 121(45)

SMITH, C. (1981) Hospital Proximity and Public Acceptance of the Mentally Ill. *Hospital & Community Psychiatry,* 32(3):178-182.

SMITH, F. (1981) Community Acceptance of Homes for Mentally Retarded People Ph.D. The University of Michigan.

SOCIAL SERVICES COMMITTEE 1984/5 Session (1985) Second Report. Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People. London: HMSO.

SPERLINGER, D. (1976) Aspects of Stability in the Repertory Grid. *British Journal of Medical Psychology,* 49: 341-347.

STAR, S. (1952) What the Public Thinks About Mental Health and Mental Illness. A Paper Presented at the Annual Meeting of the National Association for Mental Health, November,19.

STAR, S. (1955) The Public's Ideas About Mental Illness. A Paper Presented at the Annual Meeting of the National Association for Mental Health. Indianapolis, Ind.

STEADMAN, H. & COCOZZA, J. (1978) Selective Reporting and The Public's Misconceptions of the Criminally Insane. *Public Opinion Quarterly,* 41(4): 523-533.

STEADMAN, H. (1981) Critically Reassuring the Accuracy of Public perceptions of the Dangerousness of the Mentally Ill. *Journal of Health and Social Behaviour,* 22(9):310-316.

STEIN, L. & TEST, M. (1978) Commuity Treatment of the Chronic Patient:Research Overview. *Schizophrenia Bullten,* 3:350-364.

STEIN, L. & TEST, M. (1980) Alternative to Mental Hospital Treatment. *Archives of General Psychiatry,* 37:392-397.

STEINHART, I. & BOSCH, G. (1990) Rehabilitation in a Community Psychiatric \ Services, Facility Success or Failure During One Year Perid. *Rehabilitation-Stuttg,* 294:246-253.

SULLIVAN, D. & ADELSON, J. (1954) Ethnocentrism and Misanthropy. *Journal of Abnormal and Social Psychology,* 49:246-250.

TAJFEL, H., SHEIKH, A. & GARDNER, R. (1964) Content of Stereotypes and the Inference of Similarity Between Members of Stereotyped Groups. *Acta Psychologica,* 22:191-201.

TANTUM, D. (1988) Quality of Life and the Chronic Mentally Ill. *International Journal of Social Psychiatry,* 344:243-247.

TAYLOR, S., DEAR, M. & HALL, G. (1979) Attitudes Toward the Mentally Ill and Reactions to Mental Health Facilities. *Social Science and Medicine,* 13D(4):281-290.

TEAM FOR ASSESSMENT PSYCHIATRIC SERVIES (T.A.P.S.) (1990) *Moving Long-Stay Psychiatric Patients Into the Community.* First Results. London. North East Thames Region.

TEASDALE, K. (1987) Stigma and Psychiatric Day Care. *Journal of Advanced Nursing,* 12, 339-346.

TERSHAKOVEC, A. (1964) An Observation Concerning Changing Attitudes Toward Mental Illness. *American Journal of Psychiatry,* 121:353-357.

THE AUDIT COMMISSION (1986) Managing the Crisis in Council Housing, London: HMSO.

THE AUDIT COMMISSION (1987) Making a Reality of Community Care, London: HMSO.

THE ROYAL COLLEGE OF PSYCHIATRISTS, (1989) Guidelines fo Good Medical Practice in Discharge and Aftercare Procedures for Patients Discharged from In-Patient Psychiatic Treatment. Council Report CR8.

THE FRIERN HOSPITAL SURVEY (1985) A Guide for District Planning. Friern Barnet Road, Lodon.

THE COLLEGIATE TRAINEES COMMITTEE (1987) The Public Image of Psychiatry. *Bulletin of the Royal College of Psychiatrists,* 11(3):105.

THAPA, K. & ROWLAND, L. (1989) Quality of Life Perspectives in Long-Term Care: Staff and Patients Perpective. *Act Psychiatrica Scandinavica,* 80(3):267-271.

THORNICROFT, G. (1989) Deinstitutionalisation - From Hospital Closure to Services Development. *British Journal of Psychiatry,* 155(12): 739-753.

TOWNSEND, J. (1979) Stereotypes of Mental Illness. A Comarison With Ethnic Stereotypes. *Culture, Medicine and Psychiatry,* 3:205-229.

TOWELL, D. & MCAUSLAND, T. (1990) Managing Psychiatric Services in Transition-Working Paper NO.1. London, King's Fund.

TRETHOWAN, W. & SIMS, A. (1983) *Psychiatry* (5th ed.). London. Bailliere Tindall,

TRIANDIS, H. (1971) *Attitude and Attitude Change.* London. John Wiley and Sons Inc.

TRIANDIS, H. & VASSILIOUS, V. (1967) Frequency of Contact and Stereotyping. *Journal of Personality and Social Psychology,* 7(3):316-328.

TRINGO, J. (1970) The Hierarchy of Preference Toward Disability Groups. *Journal of Special Education,* 4:295-306.

TURNER, T. (1988) Community Care. *The British Journal of Psychiatry,* 152(1):1-3.

VIDICH, A. & SHAPIRO, G. (1955) A Comparison of Participant Observation and Survey Data. *American Sociological Review*, 20:28-33.

VITALO, R. & ROSS, C. (1979) Applications of the Principles of Psychiatric Rehabilitation Programming, in ANTHONY,W. (ed.): *Principles of Psychiatric Rehabilitation.* Baltimore, University Park Press.

WAHL. O. & LEFKOWITS, J. (1989) Impact of a Television Film on Attitudes Toward Mental Illness. *American Journal of Community Psychology,* 17(4):521-528.

WALKEY, F. GREEN, D. & TAYLOW, A. (1981) Community Attitudes to Mental Health : A Comparative Study. Social Science and Medicine, 15E:139-144.

WARREN, N. (1966) Social Class and Construct Systems: An Examination of the Cognitive Structure of Two Social Class Groups. *British Journal Social and Clinical Psychology,*5:254-263.

WEBB, J., WELLS, E. & HORNBLOW,A. (1986): Institution Versus Community Placements: The Effects of Different Residential Environments on the Behaviour of Intellectually Handicapped Adults. *New Zealand Medical Journal,* 199:951-954.

WEINSTIEN, R.(1979) Patients Attitudes Toward Mental Hospitalization. A Review of Quantitative Research. *Journal of Health and Social Behaviour*, 20:237-258.

WHATLEY, C. (1959) Social Attitudes Towards Discharged Mental Patients. *Social Problems,* 313-320.

WHO (1959) Social Psychiatry, The 7th Report, NO.171. Geneva.

WHORLY, L. (1978) Social Profitableness; Pathway to Community Acceptance of Psychiatric Patients. *Mental Health Sociology,* 5:183-185.

WILKINSON, D. (1982) The Effects of Brief Psychiatric Training on the Attitudes of General Nursing Students to Psychiatric Patients. *Journal of Advanced Nursing,* 7:239-253.

WING, J. & FREUDENBERG, R. (1961) The Responses of Severely Ill Chronic Scizophrenic Patients to Social Stimulation. *American Journal of Psychiatry,* 118:311.

WING, J., BENNET, D. & DENHAM, J. (1964) The Industrial Rehabilitation of Long-Stay Schizophrenic Patients. Medical Research Council Memorandum. No.2 London:HMSO

WING, J. & BROWN, G. (1970) *Institutionalism and Schizophrenia a Comparative Study of Three Mental Hospital 1960-1968.* London. Cambridge University Press.

WINGERTER, C. (1982) The Discharged Psychiatric Patient: Post - Hospital Adjustment and Factors Affecting Rehospitalization. Ph.D Theses. The University of Texas at Houston. School of Public Health.

WOLFENSBERGER, W. (1972) *Normalization The Principles of Normalization in Human Services.* National Institute on Mental Retardation. Sponsored by the Canadian Association for the Mentally Retarded.

WOLFENSBERGER, W. (1982) *The Principles of Normalisation in Human Services.* Leonard-Croford Toronto. National Institute of of Mental Retardation.

WOODWARD, J. (1951) Changing Ideas on Mental Illness and Its Treatment. *American Sociological Review,* 16:443-454.

YANKELOVICH, D. (1990) Public Attitudes Toward People With Chronic Mental Illness. The Robert Wood Johnson Foundation Program on Chronic Mental Illness. Massachusetts Mental Health Centre. 74 Fenwood R. Boston. U.S.A.

9. APPENDICES

APPENDIX 1

PUBLIC PERCEPTIONS OF DISCHARGED MENTALLY ILL IN THEIR NEIGHBOURHOOD

(S. Reda, 1986)

Date..... **Col.**
Starting time:.....
Finishing time:....
1. Interview No:...
2. Area:.....

PSYCHOSOCIAL CHARACTERISTICS

3. Sex:
   1. Male
   2. Female

4. What is your marital status?

   1. Married/Cohabitant
   2. Single
   3. Divorced
   4. Widow/er
   5. Separated

5. How old are you?(in years.....)

   1. 18 - 29
   2. 30 - 39
   3. 40 - 49
   4. 50 - 59
   5. 60 and over

6. What is your occupation?
   0. Unemployed
   1. Professional
   2. Intermediate occupation
   3. Skilled occupation
   4. Partially skilled occupation
   5. Unskilled occupation
   6. Retired
   7. Housewife
   8. Student

7. Did you study for any school certificates/have you studied for any further qualification since leaving school?

   1. Higher education
   2. A or O levels
   3. No specific certificate
   4. Others.....

8. Could you tell me who are the members of this household?
   1. Single person
   2. Couple
   3. Couple + child/ren
   4. Single parent + child/ren
   5. Others, specify.....

Col

9. Position in the family?
   1. Wife
   2. Husband
   3. Cohabitant
   4. Son/Daughter
   5. Siblings
   6. Co-resident
   7. Single person

10. How long have you been living here?
   1. less than 6 months
   2. 6 - 12 months
   3. 12- 23 months
   4. 24- 59 months
   5. 60 months and over

11. Do you own or rent your home?
   1. Own
   2. Rent
   3. Others, specify.....

THE RATER

12. Rate the type of accommodation

   1. House
   2. Flat
   3. High-rise block
   4. Council accommodation

13. Have you ever participated in any voluntary or social activities in your area?
   0. No activities
   1. Activities , e.g.
   2. Voluntary work
   3. Local church
   4. Social/sport club
   5. Community activities [e.g. community centre, parents association etc.]
   6. Political activities
   7. Resident/tenants association
   8. Others.....

14. What sort of relationship do you have with your neighbours?
   .....

Probe, would you say that you;
   0. Never have any contact with them
   1. Greet them occasionally
   2. Have casual conversation with them
   3. Exchange small services[e.g. collecting parcels , looking after the flat in their absences, etc.]
   4. Visit them
   5. Invite them in
   6. Have them as friends
   7. Have problems with neighbours
   8. Mixed relationships with the neighbours[have good relationships

with some neighbours and bad relationship with other] **Col....**

II. ATTITUDES TOWARDS MENTAL ILLNESS

15. Can you tell that somebody is Epileptic?
    1. No you cannot tell
    2. Yes you can tell
    3. Depends on the condition

16. If yes, how do you tell if someone is epileptic? Probe, what sort of behaviour do you expect?
    Disturbances of:-
    1. behaviour
    2. mood
    3. appearance
    4. interaction
    5. depends on the cause/ degree of illness

17. Do you know somebody who is epileptic?
    1. No
    2. Yes

18. Can you tell that somebody is a mentally handicapped person?
    1. No you cannot tell
    2. Yes you can tell
    3. Depends on the condition

19. If yes, how do you tell if someone is mentally handicapped? Probe, what sort of behaviour do you expect?
    Disturbances of:-
    1. behaviour
    2. mood
    3. appearance
    4. interaction
    5. depends on the cause/ degree of illness

20. Do you know somebody who is mentally handicapped?
    1. No
    2. Yes

21. Can you tell that somebody is a diabetic?
    1. No you cannot tell
    2. Yes you can tell
    3. Depends on the condition

22. If yes, how do you tell if someone is diabetic? Probe, what sort of behaviour do you expect?
    Disturbances of:-
    1. behaviour
    2. mood
    3. appearance
    4. interaction
    5. depends on the cause/ degree of illness

Col.

23. Do you know somebody who is diabetic?
    1. No
    2. Yes

24. Can you tell that somebody is mentally ill?

    1. No, you cannot tell
    2. Yes, you can tell
    3. Depends on the condition

25. If yes, how do you tell if someone is mentally ill? probe, what sort of behaviour do you expect?
    Disturbances of:-
    1. Behaviour
    2. Mood
    3. Appearance
    4. Interaction
    5. Depends on the cause/degree of illness

26. Do you know somebody who is mentally ill?
    1. No
    2. Yes

THE RATER

27. The subject does not make a distinction between mental handicap and mental illness.
    1. No distinction
    2. Yes can distinguish between them

THE RATER

28. How does the respondent identify a mentally ill person?
    1. Does stereotype
    2. Does not stereotype
    3. Bizarre/strange
    4. Aggressive
    5. Unfriendly
    6. Unusual communication
       [loud, illogical, hallucination]
    7. Facial expression
    8. Wanders about
    9. Dirty
    10 Depressed
    11 Drug/alcohol addict
    12 Sexually inappropriate behaviour
    13 Antisocial
    14 Distressed
    15 Unpredictable/changeable
    16 Lacking social skills
    17 Unusual physical movements
    18 Others, specify.....

29. Which of these conditions do you think can be cured?
    A. Mental handicap
    0. Don't know
    1. can be cured
    2. controlled
    3. cannot be cured
    4. depends on cause/
       degree of illness

B. Epilepsy **Col.**

0. Don't know
1. can be cured
2. controlled
3. cannot be cured
4. depends on cause/ degree of illness

C. Mental illness

0. Don't know
1. can be cured
2. controlled
3. cannot be cured
4. depends on cause/ degree of illness

D. Diabetes

0. Don't know
1. can be cured
2. controlled
3. cannot be cured
4. depends on cause/ degree of illness

30. Do you think there is a difference between nervous breakdown and mental illness?

0. Don't know
1. No difference
2. Yes there is a difference in:-
3. Cause
4. Duration
5. Outcome
6. Severity of illness
7. Others, specify.....

31. What do you think are the causes of mental illness?

1. Environment
2. Heredity
3. Organic
4. Accident
5. Substance abuse
6. Others, specify.....

32. Where did you get your information about mental illness?

1. Media
2. Personal experience/work/studied the subject/knows somebody mentally ill
3. Talking with other people
4. Others, specify.....

33. Do you know somebody who has had a nervous breakdown or mental illness?

1. No (If no, go to No.38)
2. Yes, specify
3. The respondent is mentally ill
4. Relative mentally ill
5. Others, specify.....

THE RATER

34. The respondent has identified the condition as:-

1. Nervous breakdown

2. Mental illness
3. Others

Col.

34a. If yes, how would you describe his/her condition?

.....

THE RATER

35. How does the respondent identify the condition?

1. The condition described as mental handicapped.
2. The condition described as mental illness

36. What sort of treatment has he/she received?

1. Community treatment
2. Hospital treatment
3. Others, specify.....

37. What were your feelings about his/her condition?

1. Positive feelings
2. Neutral feelings
3. Negative feelings

38. If someone who had been a former psychiatric patient came to live next door to you what do you think your relationship with him/her would be?.....

.....

38a [probe] would you:

0. Never have any contact with them
1. Greet them occasionally
2. Have casual conversation with them
3. Exchange small favours
4. Visit them
5. Invite them in
6. Have them as friends
7. Depends on the persons behaviour

39. If you owned a house or flat apart from where you live which of these people would you be ready to rent it to?

1. A person who had been discharged from a mental hospital
2. A person with epilepsy
3. A person with diabetes
4. A person with mental handicap
5. All of them
6. Conditional renting[capable to look after the flat, pay the rent regularly, etc.]
7. Any of them but not the mentally ill.

39a [probe] why?

.....

40. Would you attend a club which ex-psychiatric patients are also attending?

1. No
2. Yes
3. Attend under certain conditions

Col.

41. Would you work with/hire somebody who had been in a psychiatric hospital?
    1. No
    2. Yes
    3. Depends on the working conditions

42. We are not asking for money, but if you had got some money to spare which of these charitable organisations would you contribute to: and why?
    0. None
    1. Charitable organisation for diabetes
    2. Charitable organisation for mental handicap
    3. Charitable organisation for mentally ill
    4. Charitable organisation for epilepsy
    5. All the above
    5. Others organisations.....

43. Would you talk to your friends about a relative who is mentally ill?
    1. No
    2. Yes
    3. Depends on the circumstances

III OPINIONS ABOUT HOSPITAL CARE

44. Do you know someone who is in a psychiatric hospital?
    1. No
    2. Yes
    3. The respondent himself
    4. Relatives
    5. Others, specify.....

45. Have you visited a mental hospital?
    1. No
    2. Yes

46. What is your opinion about psychiatric hospital treatment?
    1. Positive
    2. Neutral
    3. Negative

47. Would you encourage a friend or a relative to seek psychiatric hospital admission if they experienced a mental illness?
    1. No
    2. Yes
    3. Yes, under certain conditions

48. Do you know of any alternatives to treatment in psychiatric hospitals?
    1. No
    2. Yes, specify.....

49. If you had mental problems yourself and had the opportunity to choose the types of treatment, where would you prefer to go?
    1. A unit in a general hospital
    2. A psychiatric hospital
    3. A private psychiatrist/ psychologist
    4. Somewhere else, specify.....

Col.

50. Would you prefer to receive treatment for a psychiatric condition in the community or in a psychiatric hospital?
    1. In the community [at home and G.P./ a nurse or Psychiatrist visit you]
    2. In a psychiatric hospital
    3. Depends on the condition
    4. Others, specify.....

IV REACTION TO PATIENT'S TRANSITION INTO THE COMMUNITY

51. Do you agree/disagree with the idea that people who have been in a psychiatric hospital and are ready for discharge, can live a normal life in the community?
    1. Agree
    2. Disagree
    3. Depends on the circumstances [services available, patients'condition]

52. If a mentally ill person is ready for discharge from a psychiatric hospital what sort of place do you think they should live in?

    1. Independent accommodation
    2. Independent accommodation with community support.
    3. Sheltered accommodation
    4. Depends on the persons' condition
    5. Special accommodation [ground floor]
    6. Start with sheltered accommodation then move them to independent accommodation.

QUESTIONS 53 to 54a to be asked in the second interview.

53. Have you heard about the opening of new mental health facilities in your area? [if no, go to question no.55.]
    1. No
    2. yes, where.....

54. Have you ever seen or dealt with the residents of the[.....]
    1. No
    2. Yes

54a If yes, can you describe the circumstances?.....

55. Do you see any advantages/disadvantages regarding the presence of mental health facilities in your area?
    0. Dont know
    1. Advantages for the local residents
    2. Advantages for discharged mentally ill
    3. Neutral.
    4. Disadvantages for local residents

Col.

56. Do you think that local residents and people roundabout can offer help for the mental health facilities in their neighbourhood?
1. No
2. Yes

57. If yes, what help could the local residents and people roundabout give to these places? 0. Don't know
1. Help within the facilities
2. Help outside the facilities

58. Do you think you should be told in the future about facilities for mentally ill people that might be opened in your area?
1. No
2. Yes
3. To be told under certain circumstances.

59. What kind of preparation or information in your opinion might someone need if patients were going to move into their neighbourhood?
0. No preparation required
1. Yes, preparation required:-
2. Background of the movers
3. Information about mental illness in general
4. Reassurance for local residents
5. Information about how to help
6. Information about the facilities
7. Conditional preparation [according to types of patients/competence of the staff]
8. Others

60. In general, do you think it is important to give the public information about mental illness?
1. No [if no go to question no.64]
2. Yes
3. Uncertain of the effect of the information

61. If yes, could you please list the items that residents would be interested to know? 1. Patient's background
2. Information about mental illness
3. Reassurance about mental illness
4. Help needed by discharged patients
5. Information about the services
6. Importance of acceptance of the mentally ill people
7. All the above
8. Others

62. Who would be the most suitable person or organisation to provide this information?
0. Don't know/no education required
1. N.H.S.
2. Local council
3. Social services

4. Patients themselves
5. Charitable organisation **Col.**
6. The government
7. The facility itself
8. All the above
9. Others

63. What is the best method of providing this information?
0. Don't know
1. Door to door discussion
2. Media
3. Newsletters
4. Public meeting
5. All the above
6. Others

64. Have you heard about the policy to close psychiatric hospitals and move patients into the community?
1. No..[if no go to no.66]
2. Yes

65. Where did you hear about hospital closure and moving patients into the community and patients moving into the community?
1. Media
2. Staff
3. Work
4. Personal experience
5. Others

66. What is your opinion about the policy to close psychiatric hospitals?
1. Positive
2. Neutral
3. Negative

67. Have you, or any member of your immediate family, ever suffered from nervous breakdown or mental illness that needed treatment?
1. Non
2. respondent himself
3. 1st degree relative
4. 2nd degree relative

68. Where did you/they go for treatment?
1. In the community
2. In the hospital
3. Others

Do you have any additional comments or suggestions?

.....

.....

.....

Thank you for your co-operation.

Interviewer comments **Col.**

69. Other people present at the interview:

1. Respondent only
2. Member of household, specify..
3. Others ,specify.....

70. Language difficulty

1. None
2. Moderate
3. Severe

71. Ethnic origion of the respondent:

1. U.K
2. Irish
3. African
4. Asian
5. Caribbean
6. European
7. Oriental (Chinese, Philipino)
8. Middle Eastern
9. Others, specify.....

Other observations:-

.....
.....
.....
.....

APPENDIX 2

RESEARCH UNIT
FRIERN HOSPITAL
FRIERN BARNET ROAD
LONDON N11 3BP

Tel. 081-368-1288 ext.222.

Dear Resident,

The Research Unit is conducting a survey of public opinions about health and illness. We would like to interview you and other residents in the neighbourhood to learn about your opinions and feelings towards people with health problems. This interview will not last more than 20-30 minutes, and we hope that you will be interested in the opportunity to express your views. What we learn from you will enable us to improve health services.

Your name was selected from the electoral register, and we would like you to understand that any information you give will be treated in strictest confidence.

I will be visiting your area starting from Monday, 17 October, 1988.

Yours sincerely,

Sawsan Reda (Miss).

RESEARCH UNIT
FRIERN HOSPITAL
FRIERN BARNET ROAD
LONDON N11 3BP

Tel. 081-368-1288 ext.222.

Dear Resident,

As you will remember, I visited you some months ago to find out your opinions about people with health problems. At the time, you kindly agreed to be seen for the second and last time to give your opinions on this subject.
I would appreciate it very much if you consider my visiting you from 17th of October 1989.
This interview will not last more than 20 minutes, and I would like you to understand that any information that you give will be treated in strictest confidence.

Your views in this second interview are vital to complete this project in order to improve health services.

Yours sincerely,

Sawsan Reda (Miss)

APPENDIX 3

REPERTORY GRID CODING SHEET

Highest score 1 Lowest score 5

	Constructs/Elements	A vagrant	Unem-ployed	A student	Generally healthy person	Mentally ill person	Mentally handicapp ed person	Alcoholic	Old age pensioner	Person you like most
1	A danger to himself/safe									
2	A danger to others/safe									
3	Angry calm									
4	Aimless/purposeful									
5	Dirty/clean									
6	Rough/polite									
7	Noisy/quiet									
8	Unlike you/like you									
9	Depressed/CheerfulL									
10	Difficult to talk to/easy to talk to									
11	Changeable/stable									
12	Looks different/looks ordinary									
13	Unfriendly/friendly									

APPENDIX 4

TAPS

Team for the Assessment of Psychiatric Services
FRIERN AND CLAYBURY HOSPITALS
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PATIENT'S ATTITUDE QUESTIONNAIRE
COMMUNITY VERSION

Sawsan Reda
Second Edition
1986

Introduction

This schedule is to be used in conjunction with the PAQ (Community Version) coding sheet. You should select the answer to each question from the numbered alternatives and then record the number in the appropriate box on the coding sheet. All boxes must be marked.

Questions should be asked in an open-ended way and expanded upon as much as is necessary to generate an answer. The interviewer should have sufficient prior knowledge of the patient's personal details and psychiatric history to enable him/her to discriminate between correct/incorrect response. The distinction between an incorrect and an unrateable response is made on the basis of the amount of relevant information provided by the patient. An incorrect response contains information relevant to the question but is factually wrong. An unrateable response does not include sufficient relevant information to assess correctness. Unrateable responses include "don't know", delusional material, and others.

SCHEDULE

Q.1 How old are you?

0. No response
1. Unrateable response
2. Incorrect response
3. Correct response

Guideline:
Code for a correct response if the answer given is within +/- 2 years of the patient's age on the date of the interview.

Q.2a What is the address of your present accommodation?

0. No response
1. Unrateable response
2. Incorrect response
3. Correct response

Guideline:
The address has four elements

i) Number or name (including name of hospital)
ii) Street name
iii) Town or District
iv) County or City or Post Code

Score for a correct response if two out of four elements are given.

Q.2b Type of accommodation:

0. No response
1. Unrateable response
2. Incorrect response
3. Correct response

Guideline:
Types of accommodation available include: hospital, hostel, private house/flat (owned or rented), council house/flat, group home, and adult fostering scheme. This list is not exhaustive and other answers may be given appropriately.

Q.3 How long have you been living here?

0. No response
1. Unrateable response
2. Incorrect response
3. Correct response

Guideline:
Code for a correct response if the answer is within 1 month of the length of stay.

Supplementary

Q.4a If less than a year in present accommodation ASK have you had any other accommodation before coming here?

0. Not applicable
1. No response
2. Unrateable response
3. No
4. Yes, specify

Q.4b If yes, what was the reason for the change?

0. Not applicable
1. No response
2. Unrateable response
3. Own decision
4. Staff decision

Q.5 Did you want to leave the hospital?

0. No response
1. Unrateable response
2. No
3. Yes

Q.6 Which do you like better - living here or living in the hospital?

0. No response
1. Unrateable response
2. Prefer here
3. Prefer hospital

Q.7 What do you like about living here?

0. No response
1. Unrateable response
2. Nothing at all
3. Company (excluding staff or care givers)
4. Outside environment
5. Inside environment
6. Food
7. Staff/care givers
8. Regime

Guideline
Outside environment includes all aspects of surroundings (e.g. atmosphere, facilities etc.). Inside environment refers to architectural features, fixtures and fittings. Regime refers to any organisational factors mentioned by the subject (e.g. independence, handling of finances). More than one category may be chosen here.

Q.8 **What do you dislike about living here?**

0. No response
1. Unrateable response
2. Nothing at all
3. Company (excluding staff or care givers)
4. Outside environment
5. Inside environment
6. Food
7. Staff/care givers
8. Regime

Q.9a **Would you like to make your home here permanently?**

0. No response
1. Unrateable response
2. No
3. Yes

Q.9b **If no, where would you like to live?**

0. Not applicable
1. No response
2. Unrateable response
3. Own home
4. With family/friends
5. Specific district named
6. Other - specify

.....
.....

Guideline
More than one category can be chosen.

Q.10a **Do you have any regular activities/duties here?**

0. Not applicable
1. No response
2. Unrateable response
3. No organised activities
4. Domestic tasks (including shopping and gardening)
5. O.T.
6. Industrial therapy
7. Social activities/games
8. Group meetings

Guideline
More than one category can be chosen.

Q.10b **If response codes 4-8, ask: overall do you find the organised activities helpful or unhelpful?**

0. Not applicable
1. No response
2. Unrateable
3. Unhelpful
4. Helpful

Q.11a Do you have regular activities/work outside the home?

0. No response
1. Unrateable response
2. No activity
3. Open employment
4. Sheltered employment/industrial therapy
5. Day hospital/day centre
6. Voluntary work
7. Social clubs/leisure activities
8. Educational activities/classes

Guideline
More than one category can be chosen.

Q.11b If response codes 3-8 ask: overall do you find these activities helpful or unhelpful?

0. Not applicable
1. No response
2. Unrateable response
3. Unhelpful
4. Helpful

Q.12 Are there any activities that you would like to be provided?

0. No response
1. Unrateable response
2. Nothing
3. Paid work
4. Voluntary work
5. O.T.
6. Leisure/social activities
7. Holidays
8. Other, specify

.....
.....

Guideline
More than one category can be chosen.

Q.13a Have you experienced any difficulties since coming here?

0. No response
1. Unrateable response
2. No
3. Yes, specify

.....
.....

Q.13b Did you ask anyone for help?

0. Not applicable
1. No response
2. Unrateable response
3. Nobody
4. Psychiatrist/GP
5. Social worker
6. Staff at the home
7. Relatives/friends
8. Another resident
9. CPN

Q.13c **Have you experienced difficulty in obtaining services from any of the following:**

0. Not applicable/services not required
1. No response
2. Unrateable response
3. Nobody
4. Psychiatrist/GP
5. Social worker
6. Staff at the residence
7. Staff in day centre/hospital
8. No difficulty
9. Others, specify

.....
.....

Guideline
More than one category can be chosen here.

Q.14 **In your contacts with any of the following people, have you found:**

a. The psychiatrist helpful or unhelpful?

0. Not applicable/services not required
1. No response
2. Unrateable response
3. Unhelpful
4. Helpful

b. The GP helpful or unhelpful?

0. Not applicable/services not required
1. No response
2. Unrateable response
3. Unhelpful
4. Helpful

c. The CPN helpful or unhelpful?

0. Not applicable/services not required
1. No response
2. Unrateable response
3. Unhelpful
4. Helpful

d. The social worker helpful or unhelpful?

0. Not applicable/services not required
1. No response
2. Unrateable response
3. Unhelpful
4. Helpful

e. Staff at the home helpful or unhelpful (Rate 0 if not applicable e.g. in unstaffed accommodation)

0. Not applicable/services not required
1. No response
2. Unrateable response
3. Unhelpful
4. Helpful

f. Other, specify helpful or unhelpful?

0. Not applicable/services not required
1. No response
2. Unrateable response
3. Unhelpful
4. Helpful

Q.15a **Have you noticed any changes in yourself since coming here?**

0. No response
1. Unrateable response
2. No change
3. Change for worse
4. Change for better

Q.15b **If yes, what kind of change?** Specify

.....
.....
.....

Q.15c **What do you think has brought about the change?** Specify

.....
.....
.....

Q.16 **If another person living in hospital asked you about the home would you recommend it as a good place to live?**

0. Not applicable
1. No response
2. Unrateable response
3. No
4. Yes

(rate "not applicable" if others would not have opportunity to live there e.g. private accommodation)

Q.17a **Do you feel that your life here is much different from life in the hospital?**

0. No response
1. Unrateable response
2. No
3. Yes

Q.17b **If yes, in what way?**

.....
.....
.....

Q.18 **If you are on medication do you find your medication helpful or unhelpful?**

0. No response
1. Unrateable response
2. Unhelpful
3. Helpful

Q.19 **If most (over 50%) of responses were "no response" or "unrateable", was it because of:**

0. Not applicable
1. Refusal
2. Incoherence
3. Poor English language
4. Muteness
5. Other reasons

APPENDIX 5

STAFF ATTITUDES TOWARDS WORKING OUTSIDE PSYCHIATRIC HOSPITALS

SAWSAN REDA (1987)

No.....
Date:.....
Interview No.....

I PERSONAL DATA

1. Sex:

2. How old are you?

3. What is your marital status?

4. Have you got childern?

5 What is your educational background?

6. What is your present position?

7a. Have you had any experience of working with psychiatric patients in the community?
7b. If yes, what was the nature of your work?

8a. Have you had any experience of working in a psychiatric hospital?
8b. If yes, what was the nature of your work?

9. Have you had experience of working in Friern or Claybury Hospitals?

10a. Have you had any experience of working with psychiatric clients (for example: hostels for adolescents or geriatric homes)?
10b. If yes, what was the nature of your work?

II. STAFF REACTIONS TO THE PSYCHIATRIC HOSPITALS CLOSURE

11. would you stronGLY AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE with the decision to close psychiatric hospitals?

12. What is your opinion about the decision to close psychiatric hospitals?

13. Do you see any advantages regarding the decision to close psychiatric hospitals?

14. Do you see any advantage regarding the decision to close psychiatric hospitals?

15. Is working in the community affecting your carrer or personal life in any way?

16 Are you prepared to continue working in the community?
b. if yes, why?
c. If no or uncertain, why?

17. From your experience, what are the effects of the imminent closure of psychiatric hospitals, do you think, on the clients?

18. what are the effects of the closure of psychiatric hospitals, do you think, on the staff?

19. what are the effects of the closure of psychiatric hospitals, do you think, on the client's relatives?

20. what are the effects of the closure of psychiatric hospitals, do you think, on the public?

21. Do you think that it is possible to avoid hospital admission for some patients currently being admitted?

22. If yes, how to avoid hospital admission or some patients ?

23. Do you think hospital are still needed?

24. If yes, what aspects of the hospitals are still needed?

III ATTITUDES TOWARDS COMMUNITY SUPPORTS?

25. How do the neighbours and people roundabout (shopkeepers) react?

26. Do you think that neighbours' reactions have affected patients' adjustment in the community? Probe, to what extent it enhanced or restricted their lives?

27. What are the facilities and agencies that you have to deal with as part of your role in the community?

28. Which were the most frequently contacted?

29. Which were most helpful? and why?

30. What were the difficulties/problems that you have experienced during working with your clients in the community?

31. What were the difficulties/problems that you have experienced with your colleagues/other personnel during working in the community?

32. What were the difficulties/problems that you have experienced with the public during working in the community?

33. How far do you think that the existing community services meet the needs of patients currently living in the community?

34. What are the community facilities/services that need to be provided for?

VI STAFF NEEDS TO WORK IN THE COMMUNITY

35. What are the staff roles of working with psychiatric clients in the community?

36. What are the staff roles in psychiatric hospitals?

37. Did you find your roles different from what you expected?

38. If yes, in what way did you find your role different?

39. From your experience what sort of preparations do long-stay psychiatric patients need before moving into the community?

40. What type of patients' behaviour hinder their adjustment in the community that you consider a problem?

41. Do you currently have any specific plans for future development of your work?

42. Do you attempt to evaluate the services you are providing?

43. Was your training/education helpful in working in the community?

44. Do you think staff members need preparation before changing to work in the community?

45. If yes, could you please list the items that should be included in a programme for staff preparation?

46a. Do you know of any training facilities for staff working with psychiatric patients in the community?

b. If yes, how could you get yourself in such training?

47. Do you think that working in the community has met your expectations regarding: a. Your career
b. Patients' progress.

48. Do you have any additional comments or suggestions?